PARTICIPANT: _____

MONTH: _____

Virginia Birth Related Neurological Injury
Claim Reimbursement Form

DATE	SERVICE RENDERED BY Account#	MILEAGE 9011	HOSPITAL 9040/9041	PHYSICIAN 9001	THERAPY 9003	PRESCRIPTION 9010	EQUIP/ REPAIR 9034/9028	NURSING 9002	OTHER
TOTALS			$ -	$ -	$ -	$ -	$ -	$ -	$ -

Total Mileage	0	Plus Mileage
Input mileage rate (see below)		Total
Mileage Reimb.	$ -	

SIGNATURE & DATE: _____ **PRINT NAME:** _____

I CERTIFY THE INFORMATION GIVEN IS ACCURATE THAT NONE OF THESE ITEMS HAVE BEEN REIMBURSED BY ANY OTHER SOURCE FOR ANY AMOUNT, NOR ARE THEY I REIMBURSEMENT FROM OTHER SOURCES.

As of January 2011

IRS mileage Rates	
Personal Car use Rate	0.51
Program Van Rate	0.255

Reviewed by: _____

TOTAL
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ELIGIBLE FOR