PARTICIPANT: _____

MONTH: _____

Virginia Birth Related Neurological Injury

Claim Reimbursement Form

DH 1/8/09

DATE	SERVICE RENDERED BY Account#	MILEAGE 9011	HOSPITAL 9040/9041	PHYSICIAN 9001	THERAPY 9003	PRESCRIPTION 9010	EQUIP/ REPAIR 9034/9028	NURSING 9002	OTHER	TOTAL
										$ -
										$ -
										$ -
										$ -
										$ -
										$ -
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										$ -
										$ -
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 ELIGIBLE FOR REIMBURSEMENT FROM OTHER SOURCES.

As of January 2009

IRS mileage Rates	
Personal Car use Rate	0.55
Program Van Rate	0.275

Reviewed by:_____