

Virginia Birth-Related Neurological Injury Compensation Program
Claim Reimbursement Form

Admitted Claimant: _____

Month: _____

DATE	DESCRIPTION/PROVIDER/SERVICES/ITEMS	MILEAGE	AMOUNT
Total Miles		-	
Miles X rate			-
Subtotal			-
Total Reimbursement			-

Signature & Date _____

Print Name: _____

Mileage Reimbursment 2024:	
Personal Car	0.67
Program Van	0.335

I certify the information given is accurate, that none of these items items have been reimbursed by any other source for any amount, nor are they eligible for reimbursement from other sources.

Reviewed By _____