MEDICAL TRANSPORTATION EXPENSE CERTIFICATION FORM

(For expenses incurred in 2016)

Medical Provider information:

Name of Medical Provider:

_____

(i.e. name of doctor, hospital, drug store, etc.)

Street Address:

_____

City, State, and Zip Code:

_____

Transportation Information:

DATE OF SERVICE	TYPE OF TRANSPORTATION (i.e. car, taxi, plane, etc.)	MILES DRIVEN MILEAGE	REIMBURSEMENT for 2016 23¢ PER MILE	PARKING/TOLLS/ OTHER EXPENSE

Employee Signature

I certify that the above expenses were paid for transportation primarily for and essential to, medical care and that they are not eligible for reimbursement under any other source.

Signature: _____ Date: _____

NOTE: Please attach this form and receipts for all transportation expenses (except mileage) to a completed Flexible Spending Account Reimbursement form.