State Accident Fund
Mileage Reimbursement Form

Injured Worker Name: **Claim No:**
Home Address:
Employer: **Date of Accident:**

Mileage must be more than 10 miles round trip
Rate: 01/01/2017 - 12/31/2017 = .535; 01/01/2018 - 12/31/2018 = .545; 01/01/2019 - 12/31/2019 = .58; 01/01/2020 - 12/31/2020 = .575; 01/01/2021 - 12/31/2021 = .56; 01/01/2022 - 6/30/2022 = .585; 7/1/2022 - 12/31/2022 = .625; 01/01/2023 - 12/31/2023= .655; 01/01/2024 - Present = .67

Date of Trip	Please include the following: From: full address (street, city, state, zip code) To: full address of the facility/doctor (street, city, state, zip code)	Round Trip Miles	Rate	Total **SAF use only**
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			

Signature of Injured Worker:______________________________ Date: _________________________

Remit to: State Accident Fund, Post Office Box 1166, Lexington, South Carolina 29071

For additional copies, please visit our website **www.saf.sc.gov**

State Fund will compare all submitted roundtrip mileage to Google Maps Driving Directions. It is recommended that you wait at least 30 days before submitting mileage so the proper documentation can be received from the Physician's office.
If this form is not completed in its entirety, it will be returned.