PHILADELPHIA AMERICAN
LIFE INSURANCE COMPANY®
P.O. Box 34952 • Omaha, NE 68134-9832

Mileage Reimbursement Form

Policy Number: _____

Policyholder Name: _____

Patient: _____

Date of Travel	Traveler's Name(s)	From: (Street Address, City, State)	To: (Street Address, City, State)	One-way mileage	Medical treatment provided by (Please attach copy of corresponding itemized billing statement)