State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION

1510 East Pershing Boulevard, South Wing
Cheyenne, Wyoming 82002
http://www.wyomingworkforce.org

Mark Gordon
Governor

Robin Sessions Cooley
Director

REIMBURSEMENT VOUCHER

NOTICE: Incomplete forms will be returned unpaid

Claim Number (REQUIRED): _____ Date of Injury: _____
Name: _____ Phone Number: _____
Physical Address: _____ ☐ Check here if new address.
City: _____ State: _____ Zip: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____

In order to obtain medical care, I traveled from my home to the location of my health care provider. Under penalty of prosecution for false statement, I certify that the information I provide on this form is true and correct. (Wyoming Statute § 27-14-511)

Signature: _____ **Date**: _____

Mileage is typically paid city to city map mileage with the exception of rural address to address.
Reimbursements with dates of service over one year will be denied

Attach original receipts for all items claimed on this form. (Credit/Debit card receipts are not sufficient)
****Please attach verification of your trip (copy of doctor's bill or note from doctor verifying date and time of appointment). Medical bills will be reimbursed for the FIRST VISIT only. You must have the provider bill the Division directly for all subsequent bills.***

From City and/or Address *(enter complete address)*	**To City and/or Address** (10 + miles one way) *(enter complete address)*	**Date**	**Time left**	**Time returned**	**Appt. Time**
_____ City_____ State _____	_____ City_____ State _____				
_____ City_____ State _____	_____ City_____ State _____				
_____ City_____ State _____	_____ City_____ State _____				
_____ City_____ State _____	_____ City_____ State _____				

Other Related Expenses (non-prescription supplies, over the counter, burial expenses not covered in funeral, hotel/motel, etc.)

Service/Expense:	**Amount Submitted:**	**Date:**

If you are seeking reimbursement for a prescription item, please complete the section below:

Name of Pharmacy/Drug/Expense:	**Amount Submitted:**	**Date:**

Meals:(Maximum of $7.00-breakfast$10.50-lunch, $17.00-dinner for a total of $34.50) Date of Trip	Note: Breakfast is allowed if travel starts at or before 6:30 a.m. due to your appointment time. Dinner if travel extends beyond 7:00 p.m. Receipt Amount

***ATTENTION CLAIMANT*:**
Sign, date and mail all originals to:
Workers' Compensation Division
1510 East Pershing Boulevard, South Wing
Cheyenne, WY 82002

Keep a copy of this document for your records

NOTE: TRAVEL WILL ONLY BE REIMBURSED TO THE CLOSEST AVAILABLE HEALTH CARE PROVIDER. W. S. § 27-14-401(D)

We invite you to take our customer service survey by visiting http://bit.ly/wyworkcomp

As public servants, we work hard every day to help ensure safe and fair workplaces with qualified workers.

CLAIMS
Phone 1-307-777-7441
Fax 1-307-777-6552
https://piers.wyo.gov