



# Travel/Appointment Verification



A Division of the Virginia Workers' Compensation Commission

Web: [www.virginiavictimsfund.org](http://www.virginiavictimsfund.org) • Mail: P.O. Box 26927, Richmond, Virginia 23261 • Phone: 1.800.552.4007 • Fax: 804.823.6905

Victim/Claimant Name:	Patient's Name ( <u>attendee of appointment</u> ):	Claim No.
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**This information is required to calculate the mileage and verify the appointment you attended**

What are you claiming? (Check one or both)	<u>DATE</u> of Appointment (number of hours there)	Please indicate the complete <b>START ADDRESS</b> (physical address / city / state / zip code)	Please indicate the complete <b>DESTINATION ADDRESS</b> (name and physical address / city / state / zip code) <b>[PLEASE INDICATE ROUND-TRIP MILEAGE]</b>	<u>Indicate the type of appointment</u> (medical, mental health, dental, criminal case/case # and purpose of appointment)	<u>Round Trip Mileage</u>	<b>SIGNATURE REQUIRED</b> if appointment is being verified by counselor, medical provider, law enforcement, or Victim/Witness advocate
<input type="checkbox"/> Travel <input type="checkbox"/> Lost Wages						
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<input type="checkbox"/> Travel <input type="checkbox"/> Lost Wages						

Victim / Claimant Signature:

Date: