INDIANA UNIVERSITY

powered by WEX

MILEAGE REIMBURSEMENT REQUEST

To receive reimbursement for mileage, you must complete this form and attach a copy of the bill from the medical provider who treated you.

Employee Name: ____________________ SSN or employee ID: ____________________

Name and Address of Medical Provider	Date(s) Incurred	Miles (Total)

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I hereby certify that the information on this form is true and accurate and that I believe these expenses are eligible under my flexible spending account. I have not and will not receive reimbursement from any other plan for these expenses. I understand that reimbursement of an expense is not a guarantee by either WEX Inc. or my employer that if audited, the IRS will allow this expense. If my claim is disallowed, I alone am responsible for interest, penalties, and taxes due as a result.

I authorize release of payment through my reimbursement account.

Employee Signature: ____________________ Date: ____________________

Where To Send a Claim:

Mail: IU HSA/FSA
Claim Reimbursement
P.O. Box 2905
Fargo, ND 58108-2905

Fax: 1-888-887-9961

Phone: 1-800-284-8412