Mark Gordon
Governor

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

5221 Yellowstone Road
Cheyenne, Wyoming 82002
http://www.wyomingworkforce.org

Robin Sessions Cooley, J.D.
Director
Elizabeth Gagen, J.D.
Deputy 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**: ______________

You have a choice of receiving benefit payments by direct deposit or prepaid debit card.
Please contact your claims analyst for more information

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: 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
5221 Yellowstone Road
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

Collaborating to support a thriving workforce and economy.

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