encova INSURANCE

ROUTINE CLAIMANT TRAVEL VOUCHER

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

TRAVEL VOUCHERS MUST BE FILED WITHIN SIX MONTHS OF THE DATE OF TRAVEL

1. Claimant name (first and last)	
2. Date of injury	3. Claim number
4. Provider name (please print)	
5. Address of point of departure (need physical address or closest route number)	

6. Date	7. One-way or round-trip	8. Total mileage

Printed name	
Authorized signature	Date

By providing my signature on this form, whether electronically or otherwise, I certify that the information provided is true and accurate to the best of my knowledge and belief.

INSTRUCTIONS FOR COMPLETING CLAIMANT TRAVEL VOUCHER

Each travel voucher can contain expenses for only ONE CLAIM and visits to ONLY ONE SERVICE PROVIDER. If information is wrong, missing or illegible, the form will be returned to you.

1. **CLAIMANT NAME:** Your full name as it appears on the letters we send you.
2. **DATE OF INJURY:** In an occupational pneumoconiosis or disease claim, this is the date of last exposure.
3. **CLAIM NUMBER:** The number assigned to your claim by Encova Insurance.
4. **PROVIDER'S NAME:** The service provider that you went to see.
5. **ADDRESS OF THE POINT OF DEPARTURE:** Encova reimburses for mileage from the claimant's residence. This street address must be written completely including street, city, state, and ZIP code. (No P.O. boxes)

After this form is completed, make a copy of this form and any receipts for your records and send the form to Encova at the address listed on the front of the form.

***NOTE:** If you are requesting reimbursement of any expense other than routine travel, refer to the Specialty Claim Travel Voucher form found on encova.com/resources.