

Complete if known:

DWC Claim #

20265809

Insurance Carrier Claim # 142-5001-218-056

## Request to get reimbursed for travel costs

Este formulario está disponible en español en el sitio web de la División en www.tdi.texas.gov/forms/dwc/dwc045brcs.pdf
Para obtener asistencia en español, llame a la División al 800-252-7031.

Filing instructions: Complete boxes 1-11 and sign the form. Send it to the insurance carrier within one year of when you incurred (charged) these costs. Keep a copy of the completed form and receipts. Do not send this form to the Division of Workers' Compensation (DWC).

## Part 1: Information about injured employee, employer, and insurance carrier

Part 1: Information about 19	2. Date of injury (mm/dd/yyyy)
1. Employee name (First, Middle, Last) SHANE RAY SUTTON	05/16/2020
3. Employee mailing address (Street or PO Box, City, State, ZIP Code) 101 Sutton Rd Gatesville, Texas 76528-3404	la a la sera miner
4. Employer (at time of injury) 4C LIVESTOCK INC	5. Employee phone number (254) 865-7432
6. Insurance carrier name Texas Mutual Insurance Company	7. Insurance carrier fax # (512) 224-3889

## Part 2: Information about travel

Date	Travel from (street address)	Travel to (health care provider's name and street address)	Miles driven (round trip)
sep20	1015 utten Re Gatesville TX 74528	24015515+5+ Temple Tx 76508	84
sep21	101 Station Rd Garesville, 1x 76528	2401531575+TempleTx765CB	84



S S S S S S S S S S S S S S S S S S S					\$
10. Sign here: Share Suffer 11. Date: 9 - 29 - 29 - 29 - 29 - 29 - 29 - 29 -				\$	\$
10. Sign here: Share Suffer 11. Date: 9 - 29 - 29 - 29 - 29 - 29 - 29 - 29 -				\$	\$
10. Sign here: Share Suffer 11. Date: 9 - 29 - 29 - 29 - 29 - 29 - 29 - 29 -				\$	\$
11. Date: 9 - 29 - 29 - 29 - 29 - 29 - 29 - 29 -				\$	\$
10. Sign here: Share Suffer 11. Date: 9 - 29 - 29 - 29 - 29 - 29 - 29 - 29 -				\$	\$
10. Sign here: Share Suffer 11. Date: 9 - 29 - 29 - 29 - 29 - 29 - 29 - 29 -	art 3: Injured en	iployee's stateme	nt		
Part 4: Insurance carrier's response to injured employee's request to get reimburstravel costs  You must provide a plain language explanation of any partial payment or denial under 28 Texas Administrative TAC) Section 134.110(f). Complete this section or use your own form and send a copy to the injured employee's representative, if any.  12. Response  Requested amount is:  Approved	and of injured cir				
Part 4: Insurance carrier's response to injured employee's request to get reimburdance costs  You must provide a plain language explanation of any partial payment or denial under 28 Texas Administrative TAC) Section 134.110(f). Complete this section or use your own form and send a copy to the injured employee's representative, if any.  12. Response Requested amount is:  Approved		mation is correct and in			
Part 4: Insurance carrier's response to injured employee's request to get reimburstravel costs  You must provide a plain language explanation of any partial payment or denial under 28 Texas Administrative (TAC) Section 134.110(f). Complete this section or use your own form and send a copy to the injured employee injured employee's representative, if any.    2. Response   Requested amount is:   Approved	certify the above infor	mation is correct and is	for travel for treatment or an exar	n for my work-	related injury.
Approved	certify the above infor 0. Sign here: 5/2 art 4: Insurance ravel costs	carrier's response	to injured employee's re	11. Date:	9-29-23 et reimbursed
Partially Denied	certify the above infor 10. Sign here: 50  Part 4: Insurance ravel costs  ou must provide a plain (AC) Section 134.110(f). Injured employee's representations.	carrier's response  I language explanation of the complete this section of the complete if any.	to injured employee's resolved and payment or denial user use your own form and send a contract of the send as a contract of the send and send as a contract of the send and send as a send	11. Date:	et reimbursed
4. Adjuster name: Christie Foster 15. License number: 16. Date:	certify the above informations.  O. Sign here:  Oart 4: Insurance of the ravel costs of t	carrier's response  I language explanation of the complete this section of the complete if any.	to injured employee's resolved and payment or denial user use your own form and send a contract of the send as a contract of the send and send as a contract of the send and send as a send	11. Date:	et reimbursed
	certify the above informations.  O. Sign here:  Oart 4: Insurance of the ravel costs.  Ou must provide a plain of the plain of the ravel costs.  Ou must provide a plain of the ravel costs.  Ou must provide a plain of the ravel costs.  Ou must provide a plain of the ravel costs.  Output Decider of the ravel costs.	carrier's response hanguage explanation of complete this section of esentative, if any.  13. Reason for deniation for deniation of the complete this section of t	to injured employee's resolution of any partial payment or denial user use your own form and send a colar.	11. Date: quest to get nder 28 Texas a opy to the inju	et reimbursed  Administrative Cocured employee and

