DWC048

TDI Division of Workers' Compensation

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

1. Employee name (First, Middle, Last) SHANE RAY SUTTON	**2. Date of injury** (mm/dd/yyyy) 05/16/2020
3. Employee mailing address (Street or PO Box, City, State, ZIP Code) 101 Sutton Rd Gatesville, Texas 76528-3404	
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

8. Trips for medical treatment and exams more than 30 miles one way.

Date	Travel from (street address)	Travel to (health care provider's name **and** street address)	Miles driven (round trip)
sep 20	101 Sutton Rd Gatesville Tx 76528	2401 S 31st St Temple Tx 76508	84
sep 21	101 Sutton Rd Gatesville, Tx 76528	2401 S 31st St Temple Tx 76508	84

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		$	$
		$	$
		$	$
		$	$
		$	$
		$	$

Part 3: Injured employee's statement

I certify the above information is correct and is for travel for treatment or an exam for my work-related injury.	
10. Sign here: Shane Sutton	**11. Date:** 9-29-23

Part 4: Insurance carrier's response to injured employee's request to get reimbursed for travel costs

You must provide a plain language explanation of any partial payment or denial under 28 Texas Administrative Code (TAC) Section 134.110(f). Complete this section or use your own form and send a copy to the injured employee and the injured employee's representative, if any.

12. Response Requested amount is: ☐ Approved ☐ Denied ☐ Partially Denied	**13. Reason for denial:**	
14. Adjuster name: Christie Foster	**15. License number:**	**16. Date:**