Medical Travel Refund Request

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)), the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act of 2000, (42 USC 7384 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Circ. 108. This form should be used for medically related travel covered by the Federal Employees' Compensation Act, the Black Lung Benefits Act and the Energy Employees Occupational Illness Compensation Program Act of 2000.

OMB No. 1240-0037
Expires: 12/31/2016

1. Claimant's Name (Last, First, Mi.):

2. Case/Claim Number:

3. Payee's Name if different from claimant's name (last, first, mi.): (See instruction no. 3 on the back of form)

4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code):

Special Instructions:
1. See reverse side of form for complete instructions and attachment of receipts.
2. Physician's signature or facsimile is **REQUIRED by BLACK LUNG** for verification of each service date and type.

5a. Date of Travel:

b. ☐ One-way ☐ Round Trip

c. Travel From:
☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To:
☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical Facility Name and Address

f. Total expense/cost
☐ Taxi $ _____
☐ Bus/Train _____
☐ Tolls/Pkg _____
☐ Lodging _____
☐ Meals _____
☐ Other _____
(Specify) _____

g. Private Auto Only
Miles traveled _____

DOL USE ONLY
TOS/Procedure Code $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician:
(Mark one box only)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

6a. Date of Travel:

b. ☐ One-way ☐ Round Trip

c. Travel From:
☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To:
☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical Facility Name and Address

f. Total expense/cost
☐ Taxi $ _____
☐ Bus/Train _____
☐ Tolls/Pkg _____
☐ Lodging _____
☐ Meals _____
☐ Other _____
(Specify) _____

g. Private Auto Only
Miles traveled _____

DOL USE ONLY
TOS/Procedure Code $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician:
(Mark one box only)
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☐ Treatment for Black Lung
☐ Not Black Lung Related
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Diagnosis
(Signature of Physician)
(Date Care Rendered)

7a. Date of Travel:

b. ☐ One-way ☐ Round Trip

c. Travel From:
☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To:
☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical Facility Name and Address

f. Total expense/cost
☐ Taxi $ _____
☐ Bus/Train _____
☐ Tolls/Pkg _____
☐ Lodging _____
☐ Meals _____
☐ Other _____
(Specify) _____

g. Private Auto Only
Miles traveled _____

DOL USE ONLY
TOS/Procedure Code $
Total $

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h. To be completed by Physician:
(Mark one box only)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
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Diagnosis
(Signature of Physician)
(Date Care Rendered)

8. **Payee's Certification:** I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

Claimant's/Payee's Signature: Date:

Instructions (Form OWCP-957)

1. Enter claimant's full name: last name, first name, middle initial.

2. Enter claimant's claim/case file number.

3. Enter payee's full name (if person other than the claimant is to be reimbursed): last name, first name, middle initial. A payee other than the claimant must have special authorization.

Please explain the following:

a. Relationship to the claimant _____

b. The reason you are requesting reimbursement

_____

4. Enter the address of the person to be reimbursed. The address is to include:
Street/RFD, City, State, Zip Code

5. 6, and 7. Complete a separate block for each medical facility visited on the same day. For travel on different days, complete one block for each date.

a. Enter date of travel.

b. Mark one box only.

c. Mark one box only.

d. Mark one box only.

e. Enter the name and address of the medical facility.

f. Mark each box for which you are claiming reimbursement and list the amount of money spent for each item.

g. Enter the total number of miles traveled by private automobile.

h. The physician or designee is to complete this item (for Black Lung use only).

8. The person claiming reimbursement must sign here.

Attach all original receipts for expenses listed in 5f, 6f, and 7f. The claimant's full name and Social Security Number should appear on each receipt.

FOR BLACK LUNG USE ONLY

Note:

_ Only travel expenses for the miner are reimbursable

_ Special approval from the district office is needed for lodging or for travel exceeding 75 miles one way or 150 miles roundtrip.

_ To obtain your district office telephone number, call toll free 1-800-638-7072.

_ Reimbursement for meals will be made only when authorized travel exceeds 24 hours or under special circumstances.

_ Travel to pick up medicine, equipment or supplies is not reimbursable.

FOR ENERGY EMPLOYEES ONLY

Note: Special approval from the district office is needed for overnight or air travel, or for travel exceeding 100 miles one way or 200 miles roundtrip. To obtain your district office telephone number, call toll free 1-866-272-2682.

Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

NOTE: Persons are not required to respond to this collection of Information unless it displays a currently valid OMB control number.