Medical Travel Refund Request



NOTE: This report is authorized by the Federa (30 USC 901; 20 CFR 725.406 and 725.701) at of 2000, (42 USC 7384 and 20 CFR 30.701). reimbursement for travel expenses. The met the Privacy Act of 1974 and OMB Circ. 108. T Employees' Compensation Act, the Black Lun Compensation Program Act of 2000.	nd the Energy Employees Oc While you are not required to hod of collecting information his form should be used for	cupational Illness Compensation o respond, this information is re- n complies with the Freedom medically related travel cover	on Program Act equired to obtain of Information Act, ed by the Federal	OMB No. 1240-0037 Expires: 08/31/2010
1. Claimant's Name (Last, First, Mi.):		2. Case/Claim Number:		
3. Payee's Name if different from claimant's	name (last, first, mi.): (Se	e instruction no. 3 on the ba	ck of form)	
4. Claimant's/Payee's Address (Street/RFD,	City, State, Zip Code):			
Special Instructions:		tructions and attachment of QUIRED by BLACK LUNG	•	service date and type.
5a. Date of Travel:	f. Total expense/cost		FOR BLACK LUNG USE ONLY	
b. One-way Round Trip		TOS/Procedure Code	h. To be completed by Physician: (Mark one box only)	
c. Travel From: d. Travel To:	Bus/Train	φ	Care	
Hospital Hospital				atment for Black Lung
Office/clinic Office/clinic	Meals			t Black Lung Related
Lab Lab	Other		Diagnosis	termine, Test for Black Lung
Home Home	(Specify)			
e. Medical facility name and address]			
	g. Private Auto Only Miles traveled	· ·	(Signat	ure of Physician)
		Total \$	(Date C	Care Rendered)
6a. Date of Travel: b. One-way Round Trip	f. Total expense/cost	DOL USE ONLY TOS/Procedure Code	FOR BLACK LUNG USE ONLY h. To be completed by Physician: (Mark one box only)	
c. Travel From: d. Travel To:	Bus/Train		Care	,
Hospital Hospital	Tolls/Pkg		Rendered Tre	atment for Black Lung
	Lodging Meals		No	t Black Lung Related
	Other			termine, Test for Black Lung
Home Home	(Specify)		Diagnosis	
e. Medical facility name and address	-			
	g. Private Auto Only Miles traveled	·	(Signat	ure of Physician)
		Total \$		are Rendered)
7a. Date of Travel:	f. Total expense/cost	DOL USE ONLY TOS/Procedure Code	h. To be completed b	ACK LUNG USE ONLY by Physician:
b. One-way Round Trip	Taxi \$ Bus/Train	\$	(Mark one box only	()
c. Travel From: d. Travel To:	Tolls/Pkg		Care Rendered Tre	
Hospital Hospital				atment for Black Lung
Office/clinic Office/clinic	Meals			t Black Lung Related
Lab Lab Home	Other (Specify)		Diagnosis	ermine, Test for Black Lung
e. Medical facility name and address				
	9. Private Auto Only Miles traveled		(Signat	ure of Physician)
		Total \$	(Date C	are 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.

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 in 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.