

CLAIMANT TRAVEL REIMBURSEMENT REQUEST

You may be reimbursed for travel related expenses to the consultative examination and/or testing location(s). Please complete, sign and return this form within 10 days after your appointment date along with the appropriate receipts (described below) to the "Return To" address listed below. Upon receipt of the completed form and appropriate receipts, travel expenses will be paid based on the round-trip distance between your address and the appointment location (shown below). If you have any questions or need assistance, please call [800 NUMBER] [CASE MANAGER'S EXTENSION]. Travel reimbursement is authorized in accordance with SSA's regulations for claimant travel and the Federal Travel Regulation.

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| Return To: | Social Security Administration [Office name placeholder] Attn: [CASE MANAGER'S NAME] PO Box 32926 Baltimore, MD 21241-2926 |
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CONSULTATIVE EXAMINATION (CE) INFORMATION

| | | |
|-------------------------|--------------------------------------------------|---------------------------------|
| Service Request Number: | [SERVICE REQUEST NO.] | |
| Name: | [CLAIMANT'S NAME] | |
| Address: | [CLAIMANT'S ADDRESS], [CLAIMANT'S CITY ,ST, ZIP] | |
| CE Provider's Name: | [VENDOR'S NAME] | |
| Appointment Location: | [VENDOR'S ADDRESS], [VENDOR'S CITY ,ST, ZIP] | |
| Appointment Date: | [APPOINTMENT DATE] | Appointment Time: [APPTMT TIME] |

TRAVEL EXPENSE INFORMATION

If you use a privately-owned vehicle to travel to the appointment, we will reimburse you at the current mileage rate in accordance with federal regulations. If you travel by mass transportation (e.g., bus, subway, etc.) you will be reimbursed at the customary rate. If you require **unusual travel arrangements** (e.g., taxi, plane, train, medically equipped vehicle, or any other mode of transportation other than privately-owned vehicle.), you must contact the Case Manager before your appointment to request pre-approval for travel reimbursement. **Failure to obtain pre-approval may result in you not being eligible for reimbursement for unusual travel expenses. For payment information, please call 1-800-582-6041.**

Please complete each item for which you are requesting reimbursement.

Please indicate your round trip mileage: I traveled _____ miles by privately-owned vehicle.

If you were required to pay any tolls, amount paid in tolls: \$ _____

If you were required to pay for parking, amount paid in parking: \$ _____

If you traveled by any other means of transportation, please complete the section below and attach the required receipts. **If you require special travel arrangements, you must obtain pre-approval in order to request reimbursement. Enter the name of the person that approved this travel and date approved:**

| | |
|-------------|-------------|
| <i>Name</i> | <i>Date</i> |
|-------------|-------------|

If you required unusual travel expenses (e.g., taxi, train, bus, plane, or any other mode of transportation other than privately-owned vehicle), enter the type of transportation used and the amount paid. **YOU MUST ATTACH RECEIPTS.**

I traveled by _____ (taxi, train, bus, etc.) and paid \$ _____ for transportation.

Please explain why this mode of transportation was necessary:

TOTAL EXPENSES: Enter your total travel expenses combined (e.g., tolls, parking, other related expenses).

\$ _____

CLAIMANT SIGNATURE

I declare under penalty of perjury that I have examined all the information I provided on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

*Signature*_____
*Date***SOCIAL SECURITY ADMINISTRATION CERTIFICATION (SSA USE ONLY)**

Certification of Payment: The travel information has been verified and reimbursement approved.

[CASE MANAGER'S NAME] *CM Signature*_____
Date

Authorization of Payment: The travel payment has been issued for \$ _____ on _____, check # _____.

*Cashier Signature*_____
*Date***PRIVACY ACT NOTICE**

The information requested on this form is authorized by the Social Security Act, Title 20 CFR 404.999a, 404.999b, 404.999c, and 404.999d. You may be reimbursed for your travel related expenses to and from your consultative examination and/or test. We need to know how much you paid in travel expenses in order to reimburse you the correct amount. The information you provide on this form will be used to calculate your round trip expenses between your address and the appointment location. Information requested on this form is voluntary. However, if you do not provide the required information, we will be unable reimburse you for your travel related expenses to and from the consultative examination and or test. While the information you furnish on this form would almost never be used for any purpose other than calculating and paying you for your travel expenses, such information may be disclosed by SSA for the following purposes (1) to assist SSA in determining the right to Social Security benefits for yourself or another person; (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of programs administered by SSA, and (3) to comply with laws and regulations requiring the exchange of information between SSA and another agency.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security Office.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*