Appendix D

Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

WTC Health Program Medical Travel Refund Request

1. Claimant's Name (Last, First, Mi.):				2. WTC ID #:
3. Payee's Name if Different from Claimant's Name (Last, First, Mi.):				
4. Claimant's/Payee's Address: (Street/RFD, City, State, Zip Code):				
5a. Date of Travel:			g. Total Expense/Cost	WTC Use Only
b. ☐ One-way ☐ Round Trip			☐ Taxi $	
c. One way distance: miles			☐ Bus/Train $	
d. Travel From:	e. Travel To:		☐ Tolls/Parking $	
☐ Hospital	☐ Hospital		☐ Lodging $	
☐ Office/Clinic	☐ Office/Clinic		☐ Meals $	
☐ Lab	☐ Lab		☐ Other $	
☐ Home	☐ Home		(Specify):	
f. Medical Facility Name and Address:				
			h. Private Auto Only	
			Miles Traveled: miles	
6a. Date of Travel:			g. Total Expense/Cost	WTC Use Only
b. ☐ One-way ☐ Round Trip			☐ Taxi $	
c. One way distance: miles			☐ Bus/Train $	
d. Travel From:	e. Travel To:		☐ Tolls/Parking $	
☐ Hospital	☐ Hospital		☐ Lodging $	
☐ Office/Clinic	☐ Office/Clinic		☐ Meals $	
☐ Lab	☐ Lab		☐ Other $	
☐ Home	☐ Home		(Specify):	
f. Medical Facility Name and Address:				
			h. Private Auto Only	
			Miles Traveled: miles	
7a. Date of Travel:			g. Total Expense/Cost	WTC Use Only
b. ☐ One-way ☐ Round Trip			☐ Taxi $	
c. One way distance: miles			☐ Bus/Train $	
d. Travel From:	e. Travel To:		☐ Tolls/Parking $	
☐ Hospital	☐ Hospital		☐ Lodging $	
☐ Office/Clinic	☐ Office/Clinic		☐ Meals $	
☐ Lab	☐ Lab		☐ Other $	
☐ Home	☐ Home		(Specify):	
f. Medical Facility Name and Address:				
			h. Private Auto Only	
			Miles Traveled: miles	

8. Claimant's/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 a false statement or misrepresentation to obtain reimbursement from the WTC Health Program is subject to civil penalties and/or criminal prosecution.

Claimant's/Payee's Signature: _____ Date: _____