

Appendix CC

WTC Health Program Medical Travel Refund Request

Form Approved
OMB No. 0920-0891
Exp. Date XXXXXX

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. <input type="checkbox"/> One-way <input type="checkbox"/> Round Trip	<input type="checkbox"/> Taxi \$	
c. One way distance: miles	<input type="checkbox"/> Bus/Train \$	
d. Travel From:	e. Travel To:	<input type="checkbox"/> Tolls/Parking \$
<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital	<input type="checkbox"/> Lodging \$
<input type="checkbox"/> Office/Clinic	<input type="checkbox"/> Office/Clinic	<input type="checkbox"/> Meals \$
<input type="checkbox"/> Lab	<input type="checkbox"/> Lab	<input type="checkbox"/> Other \$
<input type="checkbox"/> Home	<input type="checkbox"/> 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. <input type="checkbox"/> One-way <input type="checkbox"/> Round Trip	<input type="checkbox"/> Taxi \$	
c. One way distance: miles	<input type="checkbox"/> Bus/Train \$	
d. Travel From:	e. Travel To:	<input type="checkbox"/> Tolls/Parking \$
<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital	<input type="checkbox"/> Lodging \$
<input type="checkbox"/> Office/Clinic	<input type="checkbox"/> Office/Clinic	<input type="checkbox"/> Meals \$
<input type="checkbox"/> Lab	<input type="checkbox"/> Lab	<input type="checkbox"/> Other \$
<input type="checkbox"/> Home	<input type="checkbox"/> 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. <input type="checkbox"/> One-way <input type="checkbox"/> Round Trip	<input type="checkbox"/> Taxi \$	
c. One way distance: miles	<input type="checkbox"/> Bus/Train \$	
d. Travel From:	e. Travel To:	<input type="checkbox"/> Tolls/Parking \$
<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital	<input type="checkbox"/> Lodging \$
<input type="checkbox"/> Office/Clinic	<input type="checkbox"/> Office/Clinic	<input type="checkbox"/> Meals \$
<input type="checkbox"/> Lab	<input type="checkbox"/> Lab	<input type="checkbox"/> Other \$
<input type="checkbox"/> Home	<input type="checkbox"/> Home	(Specify):
f. Medical Facility Name and Address:		
h. Private Auto Only Miles Traveled: miles		

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

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: _____