Medical Travel Refund Request

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

Reset Print

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. 130. 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: 06/30/2024

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 for further requirements if payee is not the claimant)

4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code. See Instruction No. 4 for address requirements if claim is filed under the Division of Federal Employees' Compensation):

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)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
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 $

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)

8. **Payee's Certification:** I certify that the information provided is true and accurate to the best of my knowledge and belief. I am aware that any

person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain reimbursement as provided by the OWCP, or who knowingly accepts reimbursement to which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for OWCP fraud will result in termination of all current and future OWCP benefits.

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

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES.

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

Note: If your claim is filed under the Federal Employees' Compensation, please enter the following as an address: the House Number and Street Name, City/Town, State, and Zip Code.

For the FECA program to effectuate proper claims management, a FECA claimant is expected to provide the home address where he or she resides. A Post Office (PO) Box or attorney/representative address does not suffice for this purpose.

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 100 miles one way or 200 miles roundtrip.

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

_ 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.

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

REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.

Return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills.

FECA	DCMWC	DEEOIC
OWCP/DFELHWC-FECA PO Box 8300 London, KY 40742-8300 If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1966.	Federal Black Lung Program PO Box 8302 London, KY 40742-8302 If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1966.	Energy Employees Occupational Illness Compensation Programs PO Box 8304 London, KY 40742-8304 If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1966.

PUBLIC BURDEN

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary (5 U.S.C. 8101 et seq; 30 USC 901 et seq; 42 USC 7384 et seq,) to obtain or retain a benefit. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room S-3524, Washington, DC 20210, and reference the OMB Control Number 1240-0037. Note: Please do not return the completed form to this Office.

PRIVACY ACT STATEMENT

The Privacy Act of 1974, as amended (5 U.S.C. 552a) authorizes OWCP to ask for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq., the Black Lung Benefits Act (BLBA), 30 USC 901 et seq., and the Energy Occupational Illness Compensation Program Act of 2000 (EEOICPA), 42 U.S.C. 7384 *et seq., and* P.L. 103-196. The information we obtain with this form is used to identify you and to determine your eligibility for reimbursement. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-6 and DOL/ESA-49 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.
