COVID-19 TELEHEALTH PROGRAM Request for Reimbursement Form

Federal Communications Commission

OMB 3060-1271

2-19-2021

Applicant Information
[All fields mandatory unless otherwise noted]

Applicant Name

Funding Commitment Number

FCC Registration Number(FRN)

Applicant National Provider Identifier (NPI) (Optional)

Contact information [All fields mandatory]

Contact First Name

Contact Last Name

Company Name

Position Title

Mailing Address

City

State

Zip Code

Telephone Number

E-mail

Expense Information: [all fields mandatory]

Recipient Health Care Provider Name	Recipient Health Care Provider No.	Service Location (Address) or Delivery Location (Address)	Description of Service/ Connected Device(s) Purchased	Delivery Date	Quantity of Connected Device(s)/ Service(s)	Per Unit Cost of the Connected Device(s)/ Service(s)	Service Provider/ Vendor Name	Billing Period Start Date	Billing Period End Date	Service Period for Recurring Services	Total Cost

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TOTAL AMOUNT											

Certifications [Authorized Person must check all boxes and sign]

☐	I certify under penalty of perjury that the health care provider(s) listed in this request have received the COVID-19 Telehealth Program-supported services and devices listed herein.
	I certify under penalty of perjury that I am authorized to submit this request on behalf of the eligible health care provider(s) listed in this form.
	I certify under penalty of perjury that I have read the instructions relating to reimbursements and that the above costs were incurred and paid for in accordance with COVID-19 Telehealth Program rules and procedures, and I have attached the relevant supporting documents
	I certify under penalty of perjury that I have examined this form and attachments and, to the best of my knowledge, information, and belief, all information contained therein is true and correct.
	I acknowledge and certify under penalty of perjury that COVID-19 Telehealth Program funds are to be used for their intended purpose.
	I acknowledge and certify under penalty of perjury that all documentation associated with this form, including all billing records for services and/or connected devices received, must be retained for a period of at least three years after the last date of delivery of the supported-services and/or connected devices provided through the COVID-19 Telehealth Program to demonstrate compliance with COVID-19 Telehealth Program rules and requirements, subject to audit.
	I certify under penalty of perjury that the health care provider(s) listed in this form, to the best of my knowledge, is not already receiving or expecting to receive other funding (from any source, private, state, or federal) for the exact same services or devices eligible for support under the COVID-19 Telehealth Program.

Authorized Person Name	
Position Title/Company	
Mailing Address	
City	
State	
Zip Code	
Telephone	
Email Address	

Date

Digital Signature:

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 54 of the Federal Communications Commission's (FCC) rules authorize the FCC to collect the information in this form. Responses to the questions herein are required to obtain the benefits sought by this form. Failure to provide all requested information will delay the processing of the form. Information requested by this form will be available for public inspection. The information provided will be used to determine whether approving the request is in the public interest.

We have estimated that your response to this collection of information will take 1 hour. Our estimate includes the time to read the instructions, look through existing records, gather and maintain the required data, and complete and review the form or response. If you have any comments on this estimate, or on how we can improve the collection and reduce the burden it causes you, please write the Federal Communications Commission, Office of Managing Director, AMD PERM, Paperwork Reduction Act Project (3060-1271), Washington, DC 20554. We will also accept your comments via the Internet if you send them to PRA@fcc.gov. Please DO NOT SEND COMPLETED FORMS TO THIS ADDRESS.

Remember – you are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-1271.

THIS NOTICE IS REQUIRED BY THE PAPERWORK REDUCTION ACT OF 1995, P.L. 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.