Medical Travel Refund Request – Mileage

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

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)) 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 mileage. 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 and the Energy Employees Occupational Illness Compensation Program Act of 2000. For travel expenses reimbursement under the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) use the Form OWCP-957 Part B

OMB No. 1240-0037
Expires: 11/30/2026

1. Claimant Name (Last, First, M.I.):

2. Case/Claim Number:

3. Payee Name if different from claimant's name (Last, First, M.I.):
(See Instruction No. 3 for further requirements if payee is not the claimant)

4. Claimant/Payee Phone No.:

5. Claimant/Payee Address (House #, Street or RR, City, State, Zip Code):

6. Claimant/Payee Email:

Mileage ONLY Instructions

Paper form: See reverse side. On-line form: See next page.

Private Auto Only

7a. Date(s) of Travel	7b. Reason for Travel	7c. From (Full name and street address)	7d. To (Full name and street address)	7e. One-way /Round trip	7f. Total # Miles
	☐ Hospital ☐ Medical Appt. ☐ Therapy/Rehab ☐ Pharmacy ☐ Med. Supply ☐ Other			☐ One-way ☐ Round trip	
	☐ Hospital ☐ Medical Appt. ☐ Therapy/Rehab ☐ Pharmacy ☐ Med. Supply ☐ Other			☐ One-way ☐ Round trip	
	☐ Hospital ☐ Medical Appt. ☐ Therapy/Rehab ☐ Pharmacy ☐ Med. Supply ☐ Other			☐ One-way ☐ Round trip	
	☐ Hospital ☐ Medical Appt. ☐ Therapy/Rehab ☐ Pharmacy ☐ Med. Supply ☐ Other			☐ One-way ☐ Round trip	
	☐ Hospital ☐ Medical Appt. ☐ Therapy/Rehab ☐ Pharmacy ☐ Med. Supply ☐ Other			☐ One-way ☐ Round trip	

Payee 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.

Instructions – Form OWCP-957 Part A – Medical Travel Refund Request – Mileage

This is a mileage only reimbursement form. If you need other travel expenses reimbursed, complete Form OWCP-957 Part B Medical Travel Refund Request - Expenses.

1. Enter claimant's full name: last name, first name, middle initial (M.I.).
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 submit proof of special authorization. Not applicable to FECA Program.
4. Enter the Claimant's or Payee's phone number (No.) to reach with questions about this form.
5. Enter the street address of the person to be reimbursed including the: Street or Rural Route (RR), City, State, Zip Code

> **Note: For the FECA program to process your request, a FECA claimant must provide the home address where the claimant resides. A Post Office (PO) Box or attorney/ representative address is not an acceptable address.**

6. Enter the Claimant's or Payee's email address to reach with questions about this form.
7. Complete a separate block for each medical facility, pharmacy, therapist, etc. visited as follows:

Sample: Multiple trips to physical therapy office 31 miles from home.

7a. Date(s) of Travel	7b. Reason for Travel	7c. From (Full name and street address)	7d. To (Full name and street address)	7e. One-way /Round trip	7f. Total # Miles
3/2/2022	☐ Hospital	*Home*	*Therapy and Rehab 8000*	☐ One-way	*62*
3/6/2022	☐ Medical Appt.	*123 Oak St.*	*Main St*	☒ Round trip	*62*
3/10/2022	☒ Therapy/Rehab	*Everytown, OH 12345*	*Anytown, OH 54321*		*62*
	☐ Pharmacy				
	☐ Med. Supply				
	☐ Other				

a. Enter date(s) of travel. If you made multiple trips to the same location, you may enter multiple dates in this column.
b. Mark one box only.
c. Enter the full name and street address of the address where your trip started.
d. Enter the full name and street address of the address where your trip ended.
If column c or d is a medical provider, pharmacy, therapist, etc., provide the name of the medical provider or business along with their address.
e. Mark one box only.
f. If it was a one-way trip, enter the number of miles. If it was a round trip, enter the total miles traveled for both legs of the trip.

8. The person claiming reimbursement must sign and enter the date here.

Claimant/Payee Signature: _____ Date: _____

Return this completed claim form to the appropriate program address below.

Division of Federal Employees' Compensation (DFEC)	Division of Energy Employees Occupational Illness Compensation (DEEOIC)
DFEC PO Box 8300 London, KY 40742-8300	DEEOIC PO Box 8304 London, KY 40742-8304 Or submit electronically via Energy Document Portal (EDP)

To receive payment, you must have electronic banking information (Electronic Funds Transfer or EFT) on file with the appropriate program to prevent a delay in the processing of your bills. Go To https://www.fiscal.treasury.gov/files/forms/form-1199a.pdf to download and complete the EFT form. Mail your completed claim form to the appropriate program below:

DFEC PO Box 8311 London, KY 40742-8311	DEEOIC PO Box 8306 London, Kentucky 40742-8306 Or submit electronically via Energy Document Portal (EDP)
If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1966	If you have any questions regarding the completion of the form, please call Toll Free: 1-866-272-2682

FOR ENERGY EMPLOYEES ONLY

Note: Pre-authorization from the Medical Benefits Adjudication Unit is needed for travel exceeding 100 miles one way or 200 miles roundtrip. To contact the Medical Benefit Adjudication Unit call, toll free 1-866-272-2682.

BURDEN DISCLOSURE NOTICE

The public reporting burden for this data collection is estimated to average seven minutes per response. The burden estimate includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and submitting the form. This collection of information is mandatory, as it is needed by OWCP and authorized by 5 USC 8101 et seq., 30 USC 901 et seq., and 42 USC 7384d to collect this information to administer the FECA, BLBA and EEOICPA. The information collected is used to identify the eligibility of the claimant for benefits, and to determine coverage of services provided. Please send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden, and reference OMB control number 1240-0037 to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1240-0037), Washington, DC 20503. NOTE: Please do not send your completed form to this address.

PRIVACY ACT STATEMENT

We are authorized by OWCP to ask you 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.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. 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. Your response regarding the medical service(s) received or the amount charged is required to receive payment for the claim. See 20 CFR §§ 10.801, 30.701, 725.406, 725.701, and 725.704. Failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment on 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 DOUGOVT-1, DOUESA-5, DOL/ESA-6, DOU ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOUESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished. You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

NOTICE

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification 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 account for the limitations of your disability. Please contact our office or your claims examiner to ask about this assistance.