## Medical Travel Refund Request

# U.S. Department of Labor Employment Standards Administration

Office of Workers' Compensation Programs



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. 108. This form should be used for medically related travel covered by the Federal

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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	e instruction no. 3 on the ba	ck of form)
4. Claimant's/Payee's Address (Street/RFD,	City, State, Zip Code):		
Special Instructions:	•	ructions and attachment of UIRED by BLACK LUNG	receipts. for verification of each service date and type.
5a. Date of Travel:	f. Total expense/cost	DOL USE ONLY	FOR BLACK LUNG USE ONLY
b. One-way Round Trip  c. Travel From: d. Travel To: Hospital Hospital Office/clinic Office/clinic Lab	Taxi \$ Bus/Train Tolls/Pkg Lodging Meals	TOS/Procedure Code	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
Lab Lab Home  e. Medical facility name and address	Other (Specify)		Diagnosis
	g. Private Auto Only Miles traveled		(Signature of Physician)  (Date Care Rendered)
6a. Date of Travel:		DOL USE ONLY	FOR BLACK LUNG USE ONLY
b. One-way Round Trip  c. Travel From: d. Travel To: Hospital Hospital Office/clinic Office/clinic Lab Lab Home Home  e. Medical facility name and address	f. Total expense/cost  Taxi \$ Bus/Train Tolls/Pkg Lodging Meals Other (Specify)	TOS/Procedure Code  \$	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
	g. Private Auto Only Miles traveled		(Signature of Physician)
		Total \$ ———	(Date Care Rendered)
7a. Date of Travel:  b. One-way Round Trip  c. Travel From: d. Travel To: Hospital Hospital Office/clinic Office/clinic Lab Lab Home Home  e. Medical facility name and address	f. Total expense/cost  Taxi \$  Bus/Train  Tolls/Pkg  Lodging  Meals  Other (Specify)	DOL USE ONLY TOS/Procedure Code \$	h. To be completed by Physician: (Mark one box only)  Care Rendered Treatment for Black Lung Not Black Lung Related Diagnosis Diagnosis
e. Medical facility flame and address			
	9. Private Auto Only Miles traveled		(Signature of Physician)
		Total \$	(Date Care Rendered)
	t any person who knowing	gly makes any false statem	n with this form is true and correct to the best of ent or misrepresentation to obtain reimbursement
Claimant's/Payee's Signature:			Date:

Date:

#### Instructions (Form OWCP-957)

- Enter claimant's claim/case file number.
   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
- Enter the address of the person to be reimbursed. The address is to include: Street/RFD, City, State, Zip Code

1. Enter claimant's full name: last name, first name, middle initial.

- 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 75 miles one way or 150 miles roundtrip.
- To obtain your district office telephone number, call toll free 1-800-636-7072.
- Reimbursement for meals will be made only when authorized travel exceeds 24 hours or under special circumstances.
- Travel to pick up medicine, equipment or supplies in 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.

#### **Public Burden Statement**

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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