

Medical Travel Refund Request – Expenses

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)), 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: 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.):	4. Claimant/Payee Phone No.:
5. Claimant/Payee Address (House #, Street or RR, City, State, Zip Code):	6. Claimant/Payee Email:
7. Payee relationship to Claimant:	8. Reason Payee other than Claimant is requesting reimbursement:

Special Instructions:
 1. See reverse side of form for complete instructions.
 2. Physician's signature or facsimile is **REQUIRED** by **BLACK LUNG** for verification of each service date and type.

9. CLAIMANT'S TRAVEL EXPENSE REIMBURSEMENT REQUEST		For Black Lung Use Only	
Date:		DOL USE ONLY	CARE RENDERED
From: To:	<input type="checkbox"/> One-way <input type="checkbox"/> Round trip <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Appt. <input type="checkbox"/> Therapy/Rehab <input type="checkbox"/> Pharmacy <input type="checkbox"/> Med. Supply <input type="checkbox"/> Other	TOS/Procedure Code ----- \$ ----- ----- ----- ----- ----- ----- ----- ----- Total \$ -----	To be completed by Physician: (Mark one box only) <input type="checkbox"/> Treatment for Black Lung <input type="checkbox"/> Not Black Lung Related <input type="checkbox"/> Determination Testing for Black Lung _____ Diagnosis _____ Signature of Physician _____ Date Care Rendered
Total miles traveled (Private auto only): <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Pkg/Tolls <input type="checkbox"/> Taxi <input type="checkbox"/> Lodging <input type="checkbox"/> Meals <input type="checkbox"/> Other			
Other travel expenses: (Attach receipts for each listed expense)			
Specify "Other" expenses:			

Date:		DOL USE ONLY	CARE RENDERED
From: To:	<input type="checkbox"/> One-way <input type="checkbox"/> Round trip <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Appt. <input type="checkbox"/> Therapy/Rehab <input type="checkbox"/> Pharmacy <input type="checkbox"/> Med. Supply <input type="checkbox"/> Other	TOS/Procedure Code ----- \$ ----- ----- ----- ----- ----- ----- Total \$ -----	To be completed by Physician: (Mark one box only) <input type="checkbox"/> Treatment for Black Lung <input type="checkbox"/> Not Black Lung Related <input type="checkbox"/> Determination Testing for Black Lung _____ Diagnosis _____ Signature of Physician _____ Date Care Rendered
Total miles traveled (Private auto only): <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Pkg/Tolls <input type="checkbox"/> Taxi <input type="checkbox"/> Lodging <input type="checkbox"/> Meals <input type="checkbox"/> Other			
Other travel expenses: (Attach receipts for each listed expense)			
Specify "Other" expenses:			

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.

10. Claimant's/Payee's Signature: _____ **Date:** _____

Instructions - 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 have 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 Federal Employees' Compensation Act (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. If a person other than the claimant is to be reimbursed state your relationship to the claimant and provide evidence of authorization. A payee other than the claimant must have special authorization.
8. If a Payee other than the Claimant is requesting reimbursement, please state the reason the Payee is requesting reimbursement.
9. Complete a separate block for each medical facility, pharmacy, therapist, etc. visited.

Date: Enter the date of travel.

From: Enter the full street address of the address where your trip started.

To: Enter the full street address of the address where your trip ended. In the checkboxes to the right of the address field, check the box indicating whether the trip was one-way or round trip.

Total miles traveled: If you drove or were driven in a private car, enter the number of miles here for mileage reimbursement.

Other travel expenses: Check the box and enter the dollar amount spent in each category. Attach receipts for each item. If you use the "Other" checkbox, name the item in the line below the checkbox.

10. The person claiming reimbursement must sign and date here.

FOR BLACK LUNG USE ONLY

Note: Travel for diagnostic or determination examination

- Special approval from the district office is required for lodging. Pre-approval should be requested and obtained before the travel occurs.

Travel for treatment of Black Lung disease

- Special approval from the district office is needed for overnight travel, related meals and lodging, and mileage exceeding 100 miles one way or 200 miles roundtrip. Pre-approval should be requested and obtained before the travel occurs.
- To obtain your district office telephone number, call toll free 1-800-638-7072.

FOR ENERGY EMPLOYEES ONLY

Note: Special approval 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.

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

Division of Federal Employees',
Longshore and Harbor Workers'
Compensation (DFELHWC)

Division of Coal Mine Workers'
Compensation (DCMWC).

Division of Energy Employees
Occupational Illness Compensation
(DEEOIC)

Federal Employees'
Compensation Act (FECA)
PO Box 8300
London, KY 40742-8300

Black Lung Program
PO Box 8302
London, KY 40742-8302

Energy Employees Occupational
Illness Compensation Programs
PO Box 8304
London, KY 40742-8304
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: 1-800-638-7072.

If you have any questions regarding
the completion of the form, please call
Toll Free: 1-866-272-2682.

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 USC 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 USC 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 the Federal Employees' Compensation Act, 5 USC 8101 et seq.; the Black Lung Benefits Act, 30 USC 901 et seq.; and the Energy Employees 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/OWCP-2, DOL/OWCP-11 published in the Federal Register, Vol. 81, page 25766, or as updated and republished.