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.

8. Claimant/Payee Signature:

Date:

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 123 Oak St. Everytown, OH 12345	Therapy and Rehab 8000 Main St Anytown, OH 54321	☐ One-way ☒ Round trip	62
3/6/2022	☐ Medical Appt.				62
3/10/2022	☒ Therapy/Rehab				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.

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

Office of Workers' Compensation Programs

Federal Employees' Compensation Act (FECA)	**Division of Energy Employees Occupational Illness Compensation (DEEOIC)**
Division of Federal Employees', Longshore, and Harbor Workers' Compensation (DFELHWC) PO Box 8300 London, KY 40742-8300	Energy Employees Occupational Illness Compensation Program 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: 1-866-272-2682.

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.

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 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.