

Instructions (Form OWCP-957)

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

Please explain the following:

- a. Relationship to the claimant _____
- b. The reason you are requesting reimbursement

4. Enter the address of the person to be reimbursed. The address is to include:
Street/RFD, City, State, Zip Code

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 1-800-638-7072.
 - 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 is 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.