Travel Reimbursement Voucher

Martin's Point® Health Care | US Family Health Plan

To be eligible, you must be traveling 100 miles or more from your PCP office to receive required health care services.

Please return form to: US Family Health Plan Claims
PO Box 11410
Portland, ME 04104

Member's Name		
Last	First	Middle Initial
Member's US Family Health Plan ID Number		

Member's Home Address		
Number and Street	City	State and Zip Code

Primary Care Provider Name and Address		
Primary Care Provider Name		
Number and Street	City	State and Zip Code

Specialist Name and Address		
Specialist Name		
Number and Street	City	State and Zip Code

Travel Claim Information	
Dates of Travel:	Lodging—number of nights and total cost: (Lodging receipts required. Per diem reimbursement rate applies.)
Method of Travel: ☐ Automobile ☐ Train/Bus ☐ Plane	Mileage (total miles driven):
Meals (total number of meals and cost): (Meals receipts required. Per diem reimbursement rate applies.)	Member's Daytime Phone Number: (_____)_____

Member Signature _____ Date: _____

Parent/Guardian Name _____

Parent/Guardian Signature _____