Martin's Point

US FAMILY HEALTH PLAN

Travel Reimbursement Voucher

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

A Member's name

Last: _____ First: _____ Middle Initial: _____

Member ID Number: _____

B Member's home address

Number and Street: _____

City: _____ State: _____ Zip code: _____

C Primary care provider name and address

Primary care provider name: _____

Number and Street: _____

City: _____ State: _____ Zip code: _____

D Specialist name and address

Specialist name: _____

Number and Street: _____

City: _____ State: _____ Zip code: _____

E Travel Claim Information

Dates of travel: _____ Lodging—number of nights _____ Total cost: _____
(Lodging receipts required. Per diem reimbursement rate applies.)

Method of Travel: ☐ Automobile ☐ Train/Bus ☐ Plane Mileage (total miles driven): _____

Meals:Ttotal number of meals _____ Cost _____:Member's Daytime Phone Number: _____
(Meals receipts required. Per diem reimbursement rate applies.)

Member Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____