



LOGISTICARE EXPENSE REPORT- Maine

Must be sent to: LogistiCare- UR Department
400 Southborough Drive
South Portland, ME 04106

Check should be made payable to:

NAME: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP: _____

MaineCare Member Information:

NAME: _____

MaineCare ID#: _____

LOGISTICARE AUTHORIZATION/JOB#: _____

Receipts for ALL expenses
must be INCLUDED with this Expense Report.

IMPORTANT: Form must be filled out completely in order to receive reimbursement. All receipts must be received no later than 60 days after the last appointment. Receipts received after the 60 day period will not be processed.

Date:							
	SUN	MON	TUES	WED	THURS	FRI	SAT
Breakfast							
Lunch							
Dinner							
Meals Total:							
Lodging							
Other:							
Grand Total:							

Member/ guardian signature: _____

Total Amount: \$

Total amount requested: **Total amount approved:** **Processed by:** **Date:**