**LOGISTICARE EXPENSE REPORT- Maine**

**Must be sent to:** LogistiCare- UR Department
Meal Reimbursement
86 York St, Suite 2
Kennebunk, ME 04043

**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:** |
|---|---|---|---|