



For faster turnaround time, fax your claim to 410-424-4664  
 or  
 Mail to: USFHP Claims Department  
 7231 Parkway Drive, Ste 100, Hanover MD 21076

## US Family Health Plan Reimbursement Form

### Patient Information

1. Patient Name (Last, First, Middle Initial)	2. Member ID	3. Date of Birth
4. Address (Street, Apt #, City, State, Zip)	5. Telephone Numbers	6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

### Sponsor's Information

7. Sponsor Name	8. Sponsor's relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify)
9. Address (if different from patient)	10. Telephone Numbers (if different from patient)

### Please provide the following information for medical reimbursement if applicable.

11. Attach proof of Payment (canceled check, credit card receipt, electronic funds receipt)	12. Billed Amounts for each service: Total Amount:
13. Provider Information (Name, Address, ID#)	14. Procedure (CPT) Codes:
15. Dates of Service:	16. Diagnosis (DX) Codes:

### If eligible for the TRICARE Prime Travel Benefit, please provide the following information if applicable. Please use additional paper if necessary to list all transactions and include all receipts.

17. Lodging (hotel name)	18. Number of Nights:																																								
19. Mileage (complete below)	20. Meals																																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Date</th> <th style="width: 30%;">From (address)</th> <th style="width: 30%;">To (address)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Date	From (address)	To (address)																						<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Date</th> <th style="width: 80%;">Restaurant Name</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Date	Restaurant Name														
Date	From (address)	To (address)																																							
Date	Restaurant Name																																								
21. Other reimbursable expense																																									

22. Signature	23. Date
---------------	----------

### Office Use Only

Total mileage		Invoice #	
Total lodging		Calculated by	
Total meals		Reviewed by	
Total reimbursed		Date of submission to SAP	
Comments			