TRICARE SPECIALTY CARE CLAIM

PAGE OF PAGES

STATEMENT OF ACTUAL EXPENSES

REIMBURSABLE EXPENSES

DATE 20___	LODGING *(Note 1)*	LODGING TAXES	MEALS (Daily) *(Note 2)*				FUEL *(Note 3)*	AIRFARE *(Note 4)*	LOCAL TRANSPORTATION *(Note 5)*	OTHER *(Note 6)*
			Breakfast	Lunch	Dinner	Total				

NOTES

(1)Attach lodging receipt(s) as supporting document(s).
(2)Total actual, daily cost of claimant's meals and tips *(less the cost of alcoholic beverages)* for respective meals.
(3)Total actual, daily cost of fuel for authorized vehicle use.
(4)Total authorized, unreimbursed airfare – attach receipts verifying
(5) Cost of authorized transportation between residence and specialty care facility (SCF), and associated travel at destination as necessary (including travel between SCF, lodging and terminal sites). Includes rental car, taxi, shuttle, bus, rail or ferry fees, if authorized.
(6) Total cost of parking and toll expenses, and other authorized

I, _____ certify that itemized amounts above, are actual
(Type or Print Name)

and necessary expenses incurred at my expense in performance of official travel for which I have not been reimbursed.

SIGNATURE	DATE

DD FORM 1351-3, SEP 1997

This form modified August 2011 by TRICARE Regional Office - West
for Specialty Care Claims authorized under the Prime Travel Benefit Program