HEALTHTRUST℠

Performance Improvement for Healthcare

MEETING REIMBURSEMENT FORM

Facility Name: _____

Facility Address: _____

_____

Company/IDN: _____ **Date:** _____

First and Last Name: _____

			Mileage @ $0.70 /Mile				
Date(s)		**Airfare**	**Miles**	**Amount**	**Item**	**Amount**	**TOTAL**
						Total Request	

Please email this completed form along with copies of receipts no later than 30 days post meeting to:

advisoryboards@healthtrustpg.com

For Internal Use Only:

Amount of Check: $ _____ **Date check requested:** _____

Check Request Number _____

Charged against account #: 08500- **Completed by:** _____

Purpose of check: _____
Supporting documents (if indicated):

Approval: _____ **Date:** _____