LOCUMCARE

LOCUMCARE USE ONLY
Provider # _____
LocumCare #_____

Receipt Form

Provider	**Assignment Dates:**
Facility Name:	**Facility Location (city and state):**

All receipts must be attached before reimbursement can occur

	Expense Description	Date(s)	Amount
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
		Subtotal =	

Mileage Reimbursement

	From (Origin)	To (Destination)	Total Miles	Total Miles X 0.575
1.				
2.				
3.				
4.				
5.				
			Subtotal =	

Reimbursed Expenses = Assignment Expenses + Mileage
Note: Expenses over 60 days will not be eligible to be reimbursed.

Please fax completed expense report along with work log to 888.220.5658 or email to worklogs@locumcare.com