



**EMERGENCY MEDICINE EXPENSES**  
 6767 Old Madison Pike Suite 690 Huntsville, AL 35806  
**Office: 1-800-955-1919 Fax: 1-256-382-6482**

Provider #: \_\_\_\_\_  
 Job ID #: \_\_\_\_\_  
 Assign. #: \_\_\_\_\_  
 Expense Claim #: \_\_\_\_\_

<b>Provider</b>	<b>Assignment Dates:</b> ___/___/___ to ___/___/___
<b>Facility Name:</b>	<b>Facility Location:</b> City _____ State _____

**ALL RECEIPTS MUST BE ATTACHED BEFORE YOU CAN BE REIMBURSED**

	DESCRIPTION OF EXPENSE	DATES	AMOUNT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
<b>Subtotal =</b>			

**MILEAGE REIMBURSEMENT**

	FROM	TO	TOTAL MILES	TOTAL MILES X 50.0 cents
1.				
2.				
3.				
4.				
5.				
<b>Subtotal =</b>				

**REIMBURSED EXPENSES = Assignment Expenses + Mileage**

If you have any questions or concerns regarding this timesheet, please contact:

**Wyndy Anderson at 1-800-955-1919 Extension 5354**

**Please fax timesheet to 256-382-6482**