Primary Care Network HIGHLAND

Physician Services Invoice

Fax to 403-960-0039

(Local Call except Didsbury and Carstairs)

***Essential Information:**		
Date*	**Physician Name***	
Clinic*		**Phone Number***

PLEASE SUBMIT BY 15TH OF EACH MONTH FOR REIMBURSEMENT.

Date	**Description of Activity**	**Hours/Kms**	**HPCN Rate**	**Subtotal**	***Total***
	Meeting Attendance (please describe):		$200.00	$	*$*
	Mileage (for meeting attendance):		$0.505	$	$
			Total Payment Request (fax to 403-960-0039)		*$*

Signatures/Approvals

Physician Signature	Sign:
Medical Director	Sign: