VCU Health System
Virginia Commonwealth University

VA Premier Health Plan, Inc.

Travel Expense Reimbursement Form

Department of: _____

PAYEE INFORMATION MUST BE COMPLETE TO RECEIVE PAYMENT

Payee:	**Employee #**	**Phone**	
Street Address	**City**	**State**	**Zip**
Accounting Unit	**Account**	**If Applicable: Activity**	**Activity Category**

Check Which applies:

☐ VCUHS Employee ☐ Independent Contractor ☐ Other: Explain: _____

Date	Location at which expense was incurred. Points between which travel was necessary and method of transportation used. Each day's expense must be shown separately.	Miles Traveled	Mileage ($.565) Or ($.555)	Auto Rental and Gas Expense	Airfare, train & public trans	Per Diem Meals Amount	Lodging	Other (itemize in column 2)	Amount
									-
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									-
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									-
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									-
									-
	Totals		-	-	-	-	-	-	-
			665510	665520	665520	665540	665530	*See Note	

I Certify that the claimed reimbursement is accurate and was incurred by me on official business for my department.

The expenses included are only such expenses as were necessary in the conduct of this business.

Purpose of trip: _____

_____

_____

_____

_____

Signature of Traveler **Date**

Total Additional Sheet	
Grand Total	$ -
Amount Advanced (Enter as a negative to Acct 103410)	
Payment Due	$ -

Submit To:

Hopital/UHS and Physicians **PO Box 980648**

VPHP **PO Box 980318**

**Note: Please indicate account to be charged for "Other" expenses.*

Attach copy of completed Travel Authorization Form with this submission if out-of-state and/or travel expenses greater than $5,000

Only submit reimbursable expenses on this form.

For scanning purposes - please tape receipts onto a piece of paper instead of stapling.