

PATIENT CARE REIMBURSEMENT

Patient's Name: _____

Nurse's/ CNA's/Aide's Name: _____

Provider's Title (check one): RN (\$28) LPN (\$23) CNA (\$15) Personal Aide (\$12)

License #: _____ **Expiration Date:** _____

Social Security #: _____

****ORIGINALS ONLY -FAXED DOCUMENTATION WILL NOT BE ACCEPTED ****

All time sheets received after 30 days of service date will NOT be reimbursed.

DATE	HOURS WORKED (start time & end time)	TOTAL HOURS

Total Hours: _____ **X Hourly Rate \$** _____ **= \$** _____

I agree the above hours are correct:

Employer's Signature: _____

Nurse's Signature: _____

**Please mail signed, original forms to:
VACHP, 100 N. 20th Street, Suite 201, Philadelphia, PA 19103**