# Payment Voucher Worksheet

## I. Purpose:
The information below is needed to provide payment for professional services. Professional services were performed at the community health otology clinic held by Health Department on _______________ 200___ in ___________ for ____________ County.

## II. Professional Information:

<table>
<thead>
<tr>
<th>Type of Services:</th>
<th>AUDIOLOGIST</th>
<th>PHYSICIAN</th>
</tr>
</thead>
</table>

**NAME** ___________________________ **Signature** ___________________________

(Type or print) (Original signature)

Send payment to:

______________________________

If payment is to go to the contractor’s business, use Federal ID#:;

if payment is to an individual, use Social Security #.

(DO NOT USE BOTH)

______________________________

FED. I.D. #: ______________________

SOC. SEC. #: ______________________

(City) (State) (Zip Code)

**CONTACT BUSINESS PHONE NUMBER** (FOR PAYMENT QUESTIONS) __________________

Complete the items below if travel subsistence is requested. Reimbursement cannot exceed current State Standardized Travel Regulations.

**MILES TRAVELED TO/FROM CLINIC (ROUNDTRIP)** ________________________________

**LUNCH** (full day clinics only) $ ________ **LODGING** $ ________________________________

## III. Clinic Information:

**TIME CLINIC STARTED** _______________________ **TIME CLINIC ENDED** _______________________

**NUMBER OF CHILDREN SEEN BY THE PROFESSIONAL DESIGNATED IN SECTION II ABOVE** ______

**SIGNATURE** ___________________________ **DATE** ______________________

(Hearing Program Coordinator/Supervisor - LHD)

Note: This form must be completed separately and accompanied by Form DCH-0526 (H-628) for audiology and physician services to be reimbursed.

---

**MDCH USE ONLY**

(Use of this form is required for payment)

Miles _______ X _______ = Mileage $_______ Professional Services $_______ Meals $_______ Lodging $_______

**TOTAL VOUCHER AMOUNT $ ________**

DCH-0528 rev. 8/05

**Authority: P.A. 368 of 1978**