Physician payment form

GENERAL

Payee information

Name: _____ Signature: _____

Payment to be made to *(if other than physician named)*: _____

Payment information

Date *(or date range)* of activity: _____

Description of services provided or reason for payment:

Amount

Hourly amount		Flat fee amount
Number of hours:		
Hourly rate:		Amount:
Amount:	$ 0.00	
Total payment *(hourly + flat fee, if applicable)*		$ 0.00

Signed form must be submitted to finance@cwcpcn.com within **30 days**. *Scanned or digital signatures are both acceptable.*

Physician payments are processed bi-weekly; please contact finance@cwcpcn.com if your EFT information has changed.