

AHCA/NCAL 2024 Member Travel Reimbursement Request

Please email this form with receipts as one pdf document to accountspayable@ahca.org or mail to AHCA/NCAL, ATTN: Accounts Payable, 2 Massachusetts Ave NE, Unit 77880, Washington, DC 20013.

Please Print or Type

TRAVELER INFO Only ONE traveler allowed per form regardless of company.

Pay to: **Individual** OR **Company**
(please check one)

Traveler Name: _____

Company Name: _____

Mailing Address for Reimbursement:

Committee/

Meeting Name: _____

Meeting Date(s): _____

Meeting Location: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

TRAVEL Travel not to exceed maximum air travel reimbursement amount designated for each state per AHCA/NCAL Travel Policy.

- Check if you booked through AHCA/NCAL's Egencia account (no additional receipts necessary)
- Travel by commercial carrier \$ _____
(attach travel receipts if not booked through Egencia)
- Travel by car: _____ miles @ \$0.67/mile \$ _____
(attach copy of directions and map (Mapquest, Google, etc.) showing miles traveled)
- Baggage fees (attach receipts) \$ _____
- Other travel expenses (attach receipts) \$ _____
Brief description below with prior approval required:

PER DIEM See meeting notice for authorized number of days.

of days

Overnight: Outside Washington, DC (\$200/day) _____ \$ _____

Overnight: Inside Washington, DC (\$225/day) _____ \$ _____

If overnight stay is not required (\$30/day) _____ \$ _____

TOTAL \$ _____

Signature of Traveler

Date