KNOA PHARMA ASSOCIATED COMPANIES
HCP INVOICE/EXPENSE REIMBURSEMENT FORM

This form must be submitted within 15 days after the end of the month in which the expenses were incurred.

PAYABLE TO (INCLUDE MAILING ADDRESS)

Invoice Date: _____ Invoice #: _____

Full Name (including first, middle, last, suffix): _____

Address: _____

City/State: _____

Zip Code: _____ Phone: _____

State License # or NPI #: _____ State of Licensure: _____

Knoa Pharma Contact Name: _____

Purchase Order Number: _____

Detailed Description of Service(s): _____

Date(s) of Service: _____

Meeting Location (city and state that the meeting/services took place): _____

SERVICE FEE (Consulting Fee, Honoraria, etc.) $_____

OUT OF POCKET EXPENSES (This does not include expenses already paid for by Knoa Pharma; Receipts Must Be Included)

Meals (GL Code 608691) $_____

Lodging (GL Code 608692) $_____
(Includes: Room and Tax, Excludes Meals)

Transportation (GL Code 608693) $_____
(Includes: Shuttle, Car and Taxi Service, Parking, Tolls, and Mileage at the standard IRS rate)

Other Expense (GL Code 608694) $_____

_____

Please provide a detailed description of your Other Expense in the area above.

Total Out of Pocket Expenses $_____

TOTAL REIMBURSEMENT REQUEST $_____

Submission of this form to Knoa Pharma signifies HCP's agreement that the amounts are true and accurate and will be reported by Knoa Pharma consistent with State and Federal Laws, including but not limited to the Federal Physician Payment Sunshine Act.

Please email this form (with Receipts) to:
invoices@pharma.com