STRAIGHT Talk

Seminar/Office Visit Invoice

Name: _____

Address: _____

City, ST: _____

Zip: _____

Phone: _____

Invoice Number: _____

Office Use Only:
710434-806510-41000
Name: Tony Rehl (usarehl)

* Please complete with all information. If no patients seen, please enter 0.

Office Visit (OV) or Seminar **REQUIRED**	Seminar or 1/2 ($100) or Full Day ($200) **REQUIRED**	Date of OV/Seminar **REQUIRED**	Doctor's Name First and Last **REQUIRED**	# of Patients Seen **REQUIRED**	Amount Semiar = $100 ($100 or $200)

Subtotal: $ -

Mileage: x 0.565 ¢ = $ -

NOTE: If you have other reimbursements, please include receipts with your submission.

Other reimbursement:
Other reimbursement:
Other reimbursement:
Other reimbursement:

TOTAL Reimbursement: $ -

Office Signature: _____ Date: _____

Physician Office Contact Name: _____

Physician Office Contact Phone: _____

Please return the invoice and related receipts to:

Coloplast Corp. (Accounts Payable)
1601 West River Rd. Minneapolis, MN 55411
Email: suppliersUS@coloplast.com
Fax: 612-344-2301
Questions? Call: 612-287-4139