|  |  |  |
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|  |  | INVOICE |

**ALL FORMS MUST BE TYPED AND NOT HAND WRITTEN. COMPLETE ALL THE BOXES HIGHLIGHTED IN YELLOW. FAILURE TO DO THIS WILL RESULT IN PAYMENT DELAYS OR NON PAYMENT. ALL CLAIMS MUST BE MADE WITHIN 3 MONTHS OF THE COURSE DATE.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  |  | Invoice Number |  | | | | | | | |
| First Name  **IN FULL** |  | Invoice Date |  |  | / |  |  | / |  |  |
| Middle name **IN FULL** |  | PO Number |  | | | | | | | |
| Surname |  | FAO |  | | | | | | | |
| Address Line 1 |  | **Please return electronically to the relevant mailbox:**  [england.dentaladmin.yh@nhs.net](mailto:england.dentaladmin.yh@nhs.net) | | | | | | | | |
| Address Line 2 |  |
| Address Line 3 |  |
| Town/City |  |
| Post Code |  |
|  |  |  |  | | | | | | | | |
| Invoice To:  **NHS ENGLAND**  **X24 PAYABLES K005**  **PO BOX 312**  **LEEDS**  **LS11 1HP** | |  |  | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bank Account Number | Bank Account Sort Code | name on bank account | Swift code  (overseas only) | E-mail address for  remittance advice and queries |
|  |  |  |  |  | |

***NOTE: PLEASE ENSURE BANK DETAILS ARE ENTERED. FAILURE TO ENTER THESE DETAILS WILL RESULT IN PAYMENT DELAYS.***

|  |  |
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| **Total Value of the Claim** | **£** |

Please fill in the breakdown of the claim on the following page

**Details of the claim**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Travel Expenses | | | |  | | | | |  |
| Start Location: | | | | | | Finish Location: | | | |
| Public Transport | | Mode of transport:  ***(Receipts must be attached)*** | | | | | | | **£** |
| **Private Transport** | | Total Number of Miles:\_\_\_\_\_\_\_\_\_\_\_\_\_@ 56p per mile  ***(Mileage will be reimbursed at AA quickest route)*** | | | | | | | **£** |
| *Passengers*  ***(Reimbursed at 5p per mile per passenger)*** | | Name(s) of passenger(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Total miles travelled with passenger \_\_\_\_\_\_\_\_\_\_\_  ***(Passengers must be travelling to same event & also entitled to reimbursement of travel expenses by PGMDE.*** | | | | | | | **£** |
| Subsistence | | *Accommodation Expenditure*  *( Receipted expenditure to a maximum of £120 per night)* | | | | | | | **£0** |
| *Meal Expenditure*  *(Receipted expenditure to a maximum £20 per 24 hours)* | | | | | | | **£0** |
| Other Expenses | | *Please specify below:* | | | | | | | **£** |
| **DETAILS OF CLAIM (ALL CLAIMS MUST BE ACCOMPANIED BY RECEIPTS)**  **Where there is no receipt a full written explanation must be attached**  **Please read the guidance notes you obtained along with this claim form very carefully.**  **PGMDE (NHS Yorkshire and the Humber) reserves the right to reimburse the cheapest option wherever relevant.** | | | | | | | | | |
| EVENT/ACTIVITY |  | | | | | | | | |
| LOCATION |  | | | | | | | | |
| DATE(S) | From: | | | | | | To: | | |
| **Resource Fee / Backfill / Course Fee** | | | |  | | | | |  |
|  | | | | |  | | | | £ |
| **Claimant Declaration:**  I declare that the expenses claimed hereunder were necessarily incurred by me in attending the above event and are in accordance with the conditions governing the payment of travelling expenses attached. I understand that any fees are paid gross and that I am responsible, where appropriate, for declaring this income for tax purposes. | | | | | | | | | |
| **Name:** | | | **Signed:** | | | | | **Date:** | |

**Please returned this form to the appropriate NHS office for authorisation**

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| --- | --- | --- |
| ***TO BE COMPLETED BY NHS STAFF ONLY:***  **Certification of Attendance:**  I have checked this claim and am satisfied that the claimant attended the event according to the information given. | | |
| Name: | **Signed:** | **Date:** |
| **Certification of Expenses:**  This claim form has been checked and certified in accordance with NHS Travel and Subsistence Guidelines.  Any adjustments made to this claim, in line with these guidelines, have been communicated to and approved by the claimant.  Approval of such changes is attached and submitted with this document. | | |
| **Name:** | **Signed:** | **Date:** |
| **Position:** | **Contact Number:** |  |