CHECK REQUISITION

Physicians Health Plan of Northern Indiana, Inc.
1700 Magnavox Way, Ste 201
Ft. Wayne, IN 46804

DATE NEEDED _____ **VENDOR ID#** _____
REQUESTED BY _____ **PAYABLE TO** _____
ADDRESS _____
_____
CITY _____
STATE _____
ZIP _____

ACCOUNT	AMOUNT	EXPLANATION AND SPECIAL INSTRUCTIONS
MAIL		**PLEASE GIVE TO**

	SIGNATURE			APPROVAL LIMIT
SUPERVISOR/ MANAGER		**DATE**		**$5,000**
DIRECTOR		**DATE**		**$25,000**
AVP		**DATE**		**$75,000**
EXECUTIVE LEVEL		**DATE**		**$150,000**
PRESIDENT/ CEO		**DATE**		**$500,000**