

HEALTH PEI PAYMENT REQUEST

Payee Name: _____

Address: _____

Postal Code: _____

Invoice Date: _____

Invoice No.: _____

Invoice Description: _____

	Dept. Code	Service Code	Facility Code	Primary Code	Secondary Code	Program Code	Amount
G/L No.:	1						
G/L No.:							
G/L No.:							
G/L No.:						00000	
G/L No.:						00000	
G/L No.:						00000	
G/L No.:						00000	
HST			000	113820000	0000000	00000	

TOTAL _____

Details: _____

Prepared by: _____

Date: _____

Approved by: _____

Date: _____

Print Name: _____