Print Form

HEALTH PEI INVOICE REQUEST

Customer Name:							
Address:							
					Postal Code:		
Customer Account No.: (if known)					**Telephone No.:**		
					Fax No.:		
Invoice Date:					**E-mail Address:**		
Invoice Description: (info to be included on invoice)							
Description	**Dept Code**	**Service Code**	**Facility Code**	**Primary Code**	**Secondary Code**	**Program Code**	**Amount**
G/L No.:							
G/L No.:							
G/L No.:							
G/L No.:							
G/L No.:							
G/L No.:							
HST	**1**	**0000**	**000**	**413702000**	**000000000**	**00000**	
						TOTAL	

Reason for Invoice _____

_____

Requested by: _____ **Date:** _____ **Telephone #:** _____

Authorized's Signature: _____ **Date:** _____

_____ **Invoice Returned to Requestor OR** _____ **Invoice to be sent by AR**

PLEASE ENSURE SUPPORTING DOCUMENTATION IS ATTACHED. WHERE APPROPRIATE A/R WILL E-MAIL INVOICES TO CUSTOMER