**Medical Center Invoice**

# Health Care Provider Information

|  |
| --- |
| Name of Health Care Provider (please print) |
| Payable to (if different than Health Care Provider) | Vendor Email Address |
| Mailing Address (include postal code) | Telephone (include area code) | Fax (include area code) |

# Worker Information

|  |  |  |  |
| --- | --- | --- | --- |
| Invoice Date MM | DD | YY |  |
|  |
| Invoice Number |

|  |  |
| --- | --- |
| Last Name | First Name |
| Claim Number (if known) | Date of Birth MM | DD | YY |  | Date of Accident/Injury MM | DD | YY |  |
|  |  |
| Employer | Other Accident/Injury Details |

**Service Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Service MM-DD-YYYY | Description of Service/Goods | Item Amount | Item Quantity | Extended Amount |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  |  |  |  | 0.00 |
|  | **Total Due:** | $ 0.00 |
| WSCC IS GST ZERO RATED 107442691 |