

**Lancaster County Drug and Alcohol Commission**  
**LGH MAT INVOICE**

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Vendor Number: \_\_\_\_\_

Month/Year of Invoice: \_\_/\_\_\_\_

#	Client Name	Client Date of Birth	Type of Medication	Dates of Prescription Coverage	Cost Per Unit	# of Units	Total	Client Liability	Lancaster SCA Payment Amount
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
				<b>TOTALS</b>					

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_