Revised: 02/21/2023

Lancaster County Drug and Alcohol Commission
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									
				TOTALS					

Provider Signature: _____ Date: _____

Phone #: _____

S://D&A Fiscal Forms and Documents