**Remainder:** Please include the invoice number on your check.

**Terms:** Balance Due in 30 Days

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Type** | **Description** | **No. of Items** | **Cost Per Unit** | **Payment** | **Balanace** |
|  | A | Description | 5 | $10.00 | $5.00 | $4500 |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Total $ 4500

**Service Information**

**SERVICE RECEIPT INFORMATION** (Worker or other person who received service)

Service Recipient Last Name: ……………………………………………

Service Recipient DOB: ……………………………………………………..

Claim Number: ………………………………………………………………….

**PAYMENT INFORMATION**

Name: Phone#: GST Registration No:

Address: Mailing: Payee Number:

**MAIL**

Payment Services, worksafe BC

PO Box 4 700 Stn Terminal

Vancouver BC V6B 89

**INVOICE**

Invoice#: 89565

Invoice Date: 20.01.2019

Contract ID: KILO

Authorization# 9088

**MENTAL HEALTH SERVICE**



**PAYMENT SERV FAX**

**Phone:** 8956412563

**Toll Free:** 888 555 66 3

**Street Address:**

**Address2:**

**City, State, ZIP Code:**



