

**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									
				<b>TOTALS</b>					

Provider Signature: _____ Date: _____ Phone #: _____
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