MARYLAND DEPARTMENT OF HEALTH
REQUEST FOR CUSTOMER INVOICE

TO: Accounts Receivable
Division of General Accounting

FROM:

AUTHORIZATION SIGNATURE:

DATE:

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Due date: _____ (If payment due date is to be greater than 30 days, indicate here when last installment payment will be due and provide justification for the extended due date.)

Customer name:

Customer billing address:

Grand Total of Invoice: $

INDEX	PCA	AY	AOBJ	AMOUNT $	DESCRIPTION AS IT SHOULD APPEAR ON INVOICE

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For General Accounting use only:

Customer number: