

**Invoice**

*NC AHEC Bldg. T 919-445-3706*

*145 N Medical Dr. F 919-966-9175*

*Suite 400*

*Chapel Hill, NC 27599*

***Date xx/xx/xx***

***RASR ID ####***

|  |
| --- |
| **Bill To:**  |
| Name/Company NameAttention toAddress 1Address 2Address 2 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Description** | **Hour(s)** | **Rate** | **Amount** |
| Services provided**Provider**: xxx**Department**: xxxPayment due upon receipt of invoice.Please contact XXXXX with any questions: email@email.email919-445-3705 | xx | $##.## | $##.## |
| **Chartfield String** |  | **Total:** | **$##.##** |

**Please make checks payable to:**

*UNC Faculty Physicians*

*C/O General Accounting Office*

*PO Box 1250*

*Chapel Hill, NC 27514*