**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Enquiries:

Ph**: 9096 5953**

Fax: **9096 8726**

###### **PHARMACOTHERAPY DISPENSING SUPPORT PROGRAM**

**TAX INVOICE**1

Send Invoice to:

Pharmacotherapy Services

ATTN:

**Administrative support officer  
Drug Policy & Services team**

Department of Health and Human Services

GPO Box 4057

MELBOURNE 3001

or fax to **9096 8726**

PHARMACY DETAILS2

ABN:

Vendor No.3

### Client Name:

**Client Reference No.**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DATE FROM:** | **DATE TO:** | **No. of days on dosing program4** | **AMOUNT**  **(@ $5 per day)** | **GST5** | **TOTAL**  **(GST incl.)** |
|  |  |  | $ | $ | $ |

*Example*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *DATE FROM* | *DATE TO* | *No. of days on dosing program* | *AMOUNT*  *(@ $5 per day)* | *GST* | *TOTAL*  *(GST incl.)* |
| *1/07/13* | *20/07/13* | *20* | *$100.00* | *$10.00* | *$110.00* |

**NOTES:**

1. A separate Tax Invoice must be completed for each client.

2. Include your ABN number when providing Pharmacy details (name of pharmacy, address, contact no., fax no.)

3. Vendor number will be provided by the Department of Health & Human Services after your first Invoice

4. Show number of days client was on the program at your pharmacy in period.

5. GST is payable on this supply.

If you have any questions, or would like an electronic copy of this Invoice, please contact 9096 5953.

on 9096 5139.

I certify client has been dosed with methadone and/or buprenorphine between the dates shown.

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Print Name and Signature Date