CERVICAL CANCER SCREENING LABORATORY
Pap payment form

Date: _____

BC Clinical and Support Services (BCCSS)
Provincial Health Services Authority (PHSA)
Accounts Receivable
1795 Willingdon Avenue
Burnaby, BC
V5C 6E3

Dear Accounts Receivable: please charge $_____ to my Credit Card.

Please ensure the credit card expiration date is more than 3 months from the date the form is signed.
Please note we DO NOT accept Debit Visa cards.

Card #: _____ Expiry Date: _____

In the name of: _____ Contact phone #:

Email address if credit card receipt required: _____

Signature of Card Holder: _____

CODE: **PAPREV** ☐ $25.00 (Non-resident)

☐ $12.50 (Uninsured resident)

PLEASE SEND THIS PAYMENT FORM IN A SEALED ENVELOPE TO THE LAB ALONG WITH THE SAMPLE. THANK YOU!

Internal use only:
Coding: 00010-01-1203085-74104230-099