

Information:

Drawer: Accounts Payable - Invoices
Vendor Number: 1582970
Vendor Name: Dentsply Sirona Inc
Invoice Number: 46546411
Invoice Date: 06/03/21
PO Number: P0374080
Check Number: 0282263
Check Amount: \$ 1,975.51
Check Date: 06/22/2021
Department ID: 00153
Reviewer Name: Jessica Lang
Voucher Number: V0684333
Redaction Type: None
Document Type: AP Invoice

Document Below

From: Conley, Cynthia <fiske@cod.edu>
Sent: Fri Jun 04 07:20:55 CDT 2021
To: invoicing@cod.edu
CC:
Subject: DENTSPLY

Please pay the attached invoice.

Thank you,
Cindy Conley

[attachment: 204400_46546411.pdf]



Dentsply North America LLC
221 W.Philadelphia St., Suite 60W
York, PA 17401
www.dentsplysirona.com

| | |
|------------------|---------------------|
| Page 2 of 2 | Invoice 46546411 |
| Date 6/3/2021 | |

Invoice

Invoice to: COLLEGE OF DUPAGE
HSC 1122
425 FAWELL BLVD
GLEN ELLYN, IL 60137-6599

Ship to: COLLEGE OF DUPAGE
SHIPPING & RECEIVING
425 FAWELL BLVD
GLEN ELLYN, IL 60137

Past due balances are subject to 1.5% per month finance charge.
For A/R questions, please contact us at DealerCollections@dentsplysirona.com

SUBTOTAL BY SBU
Preventive - 1,975.51

| | |
|------------------|----------|
| Subtotal | 1,975.51 |
| Total Tax | 0.00 |
| Handling | 0.00 |
| Loyalty Redeemed | 0.00 |
| Total | 1,975.51 |
| Paid Credit Card | 0.00 |
| Amount Due | 1,975.51 |
| Currency | USD |

IF PAID BY CC OR COD, DO NOT DUPLICATE PAY

Web Order.....: _____

Please Remit to Address below
Dentsply Sirona Inc
Dept.DNA
P. O. Box 536935
Atlanta, GA 30353-6935

Complete the following to charge your balance
on:

- ☐ Mastercard
☐ Visa
☐ American Express
☐ Discover

Card # _____

Exp Date _____

Signature _____

Wiring Instructions:

PNC Bank
ABA#: 031000053
SWIFT#: PNCCUS33
Acct#: 8611723909
Acct: Dentsply Sirona Inc.

| Cust No. | Date | Invoice | Amount |
|----------|----------|----------|----------|
| 204400 | 6/3/2021 | 46546411 | 1,975.51 |

To the extent required by law, buyer must (i) fully and accurately disclose the amount of this discount in any cost report or claim for reimbursement submitted to Medicare, Medicaid or other federal healthcare program; and (ii) comply with any request to provide documentation of the discount to representatives of the Secretary of Department of Health and Human Services and State agencies. Refer to the Terms and Conditions for all requirements.