PROJECT FEE INVOICE

Healthcare Advisory Services

Invoice #: [00000]

Date: [MM/DD/YYYY]

ADVISOR / AGENCY

[Your Company Name]
[Address Line 1]
[City, State, Zip]
[Tax ID / NPI Number]

BILL TO

[Client Healthcare Organization]
[Contact Name]
[Department]
[Address Line 1]

Service Description / Project Milestone	Hours/Qty	Rate	Amount
[Strategic Consulting - Phase 1 Assessment]	[0.0]	$[0.00]	$[0.00]
[Regulatory Compliance Review]	[0.0]	$[0.00]	$[0.00]
[Administrative/Implementation Fees]	[0.0]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax/Adjustment: $[0.00]
Total Amount Due: $[0.00]

Payment Terms: Net [30] Days

Wire Transfer / ACH Instructions: [Bank Name] | [Account Number] | [Routing Number]

Please include invoice number with your payment. Thank you for your partnership in healthcare excellence.