DME PROVIDER NAME

123 Medical Way, Suite 100
City, State, Zip Code
Phone: (555) 000-0000
NPI: 0000000000

INVOICE

Invoice #: ___________
Date: ___________
Order ID: ___________

BILL TO:

Patient Name: ____________________
Address: __________________________
Phone: ____________________________
Policy #: __________________________

PRESCRIBING PHYSICIAN:

Doctor Name: _____________________
NPI Number: _______________________
Diagnosis Code (ICD-10): ____________

HCPCS Code	Description of Equipment/Supplies	Qty	Unit Price	Total

Subtotal: $ ___________

Tax/Shipping: $ ___________
Insurance Adjustment: ($ ___________)
Patient Responsibility: $ ___________

Notes: All rental equipment remains the property of the provider unless purchased in full. Please include the invoice number with your payment.

Payment Terms: Net 30 Days. We accept Check, Visa, and Mastercard.