[Pharmacy Name]
[Street Address]
[City, State, Zip]
Phone: [Phone Number]
License #: [License Number]

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

[Patient Name]
[Patient Address]
[City, State, Zip]
DOB: _____

PRESCRIBER INFORMATION

[Physician Name]
[Clinic/Facility]
NPI: _____
Phone: _____

Rx Number	Medication / Formula Description	Qty	Unit Price	Amount

Subtotal: $_____
Shipping/Handling: $_____
Total Due: $_____

Payment Terms: Net [Number] Days. Please make checks payable to [Pharmacy Name].

Notice: Compounded medications are prepared specifically for an individual patient and are generally non-returnable.