# DME INVOICE

Provider Name

NPI Number

Address / Phone

**INVOICE #**

**DATE**

**PATIENT INFORMATION**

Name:

ID/Policy #:

Date of Birth:

**ORDERING PHYSICIAN**

Name:

NPI:

Diagnosis Code (ICD-10):

| HCPCS Code | Description of Equipment/Supplies | Qty | Unit Price | Total |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Subtotal: $ _____
Insurance Paid: $ _____
Patient Responsibility: $ _____

Assignment of Benefits: I authorize payment of medical benefits to the provider for services described above.

Patient/Guardian Signature

Date