INVOICE

[Company Name]
[Business Address]
[Phone Number]
[Tax ID/NPI Number]

Invoice #: _____
Date: _____

PATIENT / BILL TO:

[Patient Name]
[Patient Address]
[Insurance ID Number]
[Date of Birth]

CLINICAL INFORMATION:

Referring Physician: _____
Date of Service: _____
Diagnosis Code (ICD-10): _____

HCPCS Code	Description of Device/Component	Qty	Unit Price	Total
_____	_____	___	$_____	$_____
_____	_____	___	$_____	$_____
_____	_____	___	$_____	$_____

Subtotal: $_____
Tax / Adjustments: $_____

Total Amount: *$*_____

Notes: All prosthetic devices are custom-fitted. Warranty information is attached per manufacturer guidelines.

Authorization: I acknowledge receipt of the items listed above and authorize payment of medical benefits to the provider.

Signature: _____ Date: _____