[Provider Name / Practice Name]
[Address Line 1]
[Address Line 2]
[Phone Number]
[Email Address]

INVOICE

Invoice #: [Number]
Date: [Date of Issue]

PROVIDER INFORMATION
NPI Number: [NPI #]
Tax ID/EIN: [Tax ID]
License #: [License #]

PATIENT INFORMATION
Name: [Patient Name]
DOB: [Date of Birth]
Address: [Patient Address]

INSURANCE DETAILS
Member ID: [ID #]
Group #: [Group #]
Diagnosis Code (ICD-10): [Code]

Date of Service	CPT Code	Description	Units	Fee
[Date]	[e.g., 90837]	[Psychotherapy, 60 min]	1	$0.00
[Date]	[e.g., 90834]	[Psychotherapy, 45 min]	1	$0.00

Total Billed: $0.00

Amount Paid by Patient: $0.00

Balance Due: $0.00

Provider Signature: _____

This is a "Superbill" provided for the purpose of insurance reimbursement. Please submit this document directly to your insurance carrier.