

[Family Practice Name]

[Clinic Address Line 1]
[City, State, Zip]
Phone: (555) 000-0000

INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]

PATIENT INFORMATION

[Patient Full Name]
[Address]
[Phone Number]
DOB: [MM/DD/YYYY]

INSURANCE INFORMATION

Provider: [Insurance Name]
ID: [Policy Number]
Group: [Group ID]

Date of Service	CPT Code	Description of Service	Charges
[Date]	[99213]	Office Visit - Established Patient	\$0.00
[Date]	[80053]	Comprehensive Metabolic Panel	\$0.00

Total Charges: \$0.00
Insurance Paid: (\$0.00)
Patient Copay/Coinsurance: \$0.00

Total Balance Due: \$0.00

Provider: [Physician Name, MD/DO] | **NPI:** [0000000000]

Please make checks payable to: [Clinic Name]. Payments are due within 30 days of receipt.