SPECIALIST CONSULTATION

[Clinic/Hospital Name]
[Medical License Number]
[Street Address]
[City, State, Zip]
[Phone Number]

MEDICAL INVOICE

Invoice #: _____
Date: _____
Reference: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____
Address: _____

SPECIALIST INFORMATION

Doctor: _____
Department: _____
NPI/Provider ID: _____
Referral Source: _____

Date of Service	CPT/ICD Code	Description of Services / Procedures	Amount

Subtotal: $ _____
Insurance Adjustment: ($ _____)
Amount Paid: ($ _____)

TOTAL DUE: $ _____

Payment Terms: Due upon receipt. Please make checks payable to "[Practice Name]".

Notes: _____

Thank you for choosing our specialized care.