Cardiology Consultation Invoice

Clinic Name: _____
Physician: _____
NPI/Provider ID: _____

Invoice #: _____
Date: ____/____/20____

Patient Information:
Name: _____
DOB: ____/____/_____
ID/Policy #: _____
Billing Information:
Insurance Carrier: _____
Referring Physician: _____

CPT Code	Description of Service	Units	Amount
99244	Outpatient Consultation (Level 4)	____	$ _____
93000	Electrocardiogram (ECG/EKG)	____	$ _____
93306	Echocardiogram, Transthoracic (TTE)	____	$ _____
	Other: _____	____	$ _____

Subtotal: $ _____

Insurance Adjustment: $ (_____)

Patient Co-pay/Balance: $ _____

Diagnosis (ICD-10): _____

Payment Terms: Net 30 days. Please include invoice number on all payments.

Contact: (____) ____-_____ | Email: _____