CLINICAL INVOICE

[Practitioner Name / Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number]
NPI: [Provider NPI Number]
Tax ID: [Tax ID Number]

Invoice #: ___________
Date: ___________
Due Date: ___________

BILL TO:

[Patient Name]
[Patient Address]
[City, State, Zip]
Patient ID: ___________

INSURANCE INFORMATION:

Payer: [Insurance Co. Name]
Policy #: ___________
Group #: ___________
Auth #: ___________

Date of Service	CPT / HCPCS Code	Description	Units	Rate	Total

Subtotal: $__________

Insurance Paid: ($________)

Patient Responsibility: ($________)

TOTAL AMOUNT DUE: $________

Notes / Diagnosis (ICD-10): ____

Please make checks payable to: [Practitioner Name]. Payment is expected within [X] days of invoice date.

Thank you for choosing our clinical services.