

GERIATRIC MEDICAL SERVICES

123 Senior Care Way
Medical District, ST 12345
Phone: (555) 012-3456

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID/MRN: _____
Caregiver: _____

BILLING DETAILS

Responsible Party: _____
Insurance: _____
Policy #: _____
Due Date: _____

Service Description / CPT Code	Date of Service	Qty	Unit Price	Amount
Initial Comprehensive Geriatric Assessment (99205)		1	\$	\$
Cognitive Functional Assessment		1	\$	\$
Medication Reconciliation & Review		1	\$	\$

Subtotal: \$ _____
Insurance Adjustment: (\$ _____)
Balance Due: \$ _____

Notes: _____

Payment is appreciated at the time of service or within 30 days of the invoice date. Please make checks payable to "Geriatric Medical Services".