INVOICE

Practice Name
Clinic Address Line 1
City, State, ZIP
Phone: (555) 000-0000

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID/MRN: _____

BILLING/INSURANCE

Provider: _____
Policy #: _____
Auth #: _____

Service Date	CPT/ICD Code	Description of Obstetric Service	Amount
		Prenatal Consultation	$
		Ultrasound / Imaging	$
		Laboratory Tests	$
			$

Subtotal: $_____
Insurance Paid: ($_____)

Total Due: $_____

Notes: _____

Please make all checks payable to the practice name listed above. Thank you.