

# MEDICAL INVOICE

Practice Name: \_\_\_\_\_

Provider ID: \_\_\_\_\_

Address: \_\_\_\_\_

Invoice #: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

---

## PATIENT INFORMATION

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

ID/Policy #: \_\_\_\_\_

## REFERRING PHYSICIAN

Name: \_\_\_\_\_

NPI/Reg #: \_\_\_\_\_

Date of Service	CPT/HCPCS Code	Description of Services	Charges

Subtotal: \$ \_\_\_\_\_  
Insurance Adjustment: (\$ \_\_\_\_\_)  
Total Due: \$ \_\_\_\_\_

---

**Payment Terms:** Due within \_\_\_ days. Please make checks payable to \_\_\_\_\_.

**ICD-10 Diagnosis Codes:** \_\_\_\_\_

*This document serves as an official medical statement for insurance reimbursement purposes.*