URGENT CARE CENTER

123 Medical Plaza
City, State, Zip
Phone: (555) 000-0000

INVOICE

Invoice #: [000000]
Date: [MM/DD/YYYY]
Service Date: [MM/DD/YYYY]

PATIENT INFORMATION:

[Patient Name]
[Address Line 1]
[City, State, Zip]
DOB: [MM/DD/YYYY]

INSURANCE / BILLING:

[Provider Name]
ID: [ID Number]
Group: [Group Number]

CPT Code	Description of Service	Qty	Unit Cost	Total
[99214]	Urgent Care Office Visit - Level 4	1	$0.00	$0.00
[87880]	Rapid Diagnostic Test (Strep/Flu/COVID)	1	$0.00	$0.00
[Supplies]	Clinical Supplies / Lab Processing	1	$0.00	$0.00

Subtotal: $0.00
Insurance Adjust: ($0.00)
Copay Paid: ($0.00)

Amount Due: $0.00

Payment Terms: Due upon receipt. Please make checks payable to "Urgent Care Center".

Notes: This is a formal statement of services rendered. For clinical questions regarding this consultation, please contact our medical records department.