Pediatric Allergy & Immunology

[Clinic Name]
[Clinic Address]
[Phone Number]
[Tax ID / NPI]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Guardian: _____

INSURANCE INFORMATION

Provider: _____
Policy #: _____
Group #: _____

Date of Service	CPT Code / Description	Diagnosis (ICD-10)	Amount
	Initial Consultation / Allergy Skin Testing		$
	Immunotherapy (Allergy Shots)		$

Date of Service	CPT Code / Description	Diagnosis (ICD-10)	Amount
	Pulmonary Function Test (Spirometry)		$
	Laboratory Fees (IgE Testing)		$

Subtotal: $ _____
Insurance Adjustment: - $ _____
Co-pay / Paid: - $ _____
Balance Due: $ _____

Payment Terms: Please make checks payable to [Clinic Name]. Payment is due within 30 days of invoice date.

Clinical Note: If you have questions regarding specific allergy serum or testing codes, please contact our billing department.