

# PEDIATRIC ENDOCRINOLOGY CARE

123 Medical Plaza, Suite 400  
City, State, ZIP  
Phone: (555) 012-3456

## INVOICE

Date: [Date]  
Invoice #: [00000]

### PATIENT INFORMATION

[Patient Full Name]  
DOB: [MM/DD/YYYY]  
Parent/Guardian: [Name]  
ID: [Patient ID/MRN]

### BILLING INFORMATION

[Responsible Party Name]  
[Billing Address]  
[City, State, ZIP]  
Insurance: [Provider Name / Policy #]

Service Date	Description / CPT Code	Qty	Unit Cost	Total
[Date]	Level 4 Outpatient Office Visit (99214)	1	\$0.00	\$0.00
[Date]	Hemoglobin A1c Point of Care (83036)	1	\$0.00	\$0.00
[Date]	Continuous Glucose Monitor Interpretation (95251)	1	\$0.00	\$0.00

Service Date	Description / CPT Code	Qty	Unit Cost	Total
[Date]	Growth Hormone Stimulation Test	1	\$0.00	\$0.00

Subtotal: \$0.00

Insurance Adjustment: (\$0.00)

Amount Due: \$0.00

**Notes:** Please make checks payable to "Pediatric Endocrinology Care". Payment is due within 30 days of receipt.

For billing inquiries, please contact our financial department at [billing@example.com](mailto:billing@example.com).