PEDIATRIC NEPHROLOGY INVOICE

[Clinic/Hospital Name]
[Clinic Address]
[Contact Information]

Invoice #: _____
Date: _____

PATIENT INFORMATION (MINOR)

Name:
DOB:
Weight (kg):
Patient ID:

PARENT / LEGAL GUARDIAN

Name:
Billing Address:
Insurance Provider:
Policy #:

Code	Description of Services / Treatment	Qty	Unit Cost	Total
99214	Consultation / Specialist Follow-up			
90935	Hemodialysis Procedure / Renal Replacement Therapy			
81001	Urinalysis / Labs			
76770	Renal Ultrasound			
	Medication / Immunosuppressants			

Code	Description of Services / Treatment	Qty	Unit Cost	Total

Subtotal: $_____
Insurance Adjustment: ($_____)
Amount Due: $_____

NOTES / PHYSICIAN COMMENTS

Payment is due within 30 days. Please make checks payable to the provider listed above. For questions regarding pediatric renal billing codes or insurance coverage, contact the billing department.