PEDIATRIC ONCOLOGY CENTER

[Hospital Address Line 1]
[City, State, Zip]
Phone: (555) 000-0000

INVOICE

Date: [Date]
Invoice #: [00000]
Patient ID: [PID-000]

PATIENT INFORMATION

[Patient Full Name]
DOB: [MM/DD/YYYY]
Parent/Guardian: [Name]
Address: [Address, City, State]

INSURANCE INFORMATION

Provider: [Insurance Name]
Policy #: [Policy Number]
Group #: [Group Number]
Authorization: [Auth Code]

Date of Service	Description of Treatment/Procedure	CPT Code	Amount
[Date]	Chemotherapy Administration - [Drug Name]	[96413]	$0.00
[Date]	Oncology Consultation/Evaluation	[99214]	$0.00
[Date]	Laboratory Services - Complete Blood Count	[85025]	$0.00

Date of Service	Description of Treatment/Procedure	CPT Code	Amount
[Date]	Infusion Supplies & Pharmacy Materials	[HCPCS]	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Balance Due: $0.00

Please make checks payable to "Pediatric Oncology Center".
For billing inquiries, please contact the Patient Finance Office at extension [000].
Thank you for allowing us to care for your child.