CARDIAC SURGERY INVOICE

[Hospital/Clinic Name]
[Department of Cardiovascular Surgery]
[Street Address, City, State, ZIP]

Invoice #: _____
Date: _____
Case ID: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____

PROCEDURE DETAILS

Primary Surgeon: _____
Procedure Date: _____
Procedure: _____

Service/Supply Description	Code (CPT/HCPCS)	Qty/Units	Unit Price	Amount
Surgical Professional Fee (Primary Procedure)		1		
Anesthesia Services (Base + Time)				
Operating Room Facilities / Equipment				
Cardiopulmonary Bypass (Perfusion)				

Service/Supply Description	Code (CPT/HCPCS)	Qty/Units	Unit Price	Amount
Implants / Prosthetics (Valves, Grafts, Stents)				
Post-Operative Recovery (ICU/HDU)				
Specialized Cardiac Medications/Supplies				
Subtotal:				_____
Insurance Adjustment:				_____
Tax:				_____
Total Due:				**$_____**

Payment Terms: Net 30 days. Please make checks payable to [Organization Name].

For billing inquiries, please contact the Patient Financial Services department at [Phone Number] or [Email Address].