[HOSPITAL NAME]
[DEPARTMENT OF EMERGENCY SURGERY]
[STREET ADDRESS]
[CITY, STATE, ZIP]

SURGICAL INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____
Insurance: _____

PROCEDURE DETAILS

Surgeon: _____
Anesthesiologist: _____
Date of Surgery: _____
OR Room #: _____

Description of Service / Code (CPT/ICD)	Qty/Hrs	Unit Price	Total
Emergency Room Triage/Stabilization			
Surgical Suite Access (Emergency)			
Primary Procedure: _____			
Anesthesia Services			
Medical Supplies & Consumables			
Post-Op Recovery/PACU			

Subtotal: $_____
Insurance Adjustment: ($_____)

Amount Due: $_____

Notes/Observations:
_____

Authorized Signature: _____ **Date:** _____