INVOICE

[Facility Name]
[Address Line 1]
[City, State, Zip]
[Phone Number]

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

PROCEDURE DETAILS

Referring MD: _____
Procedure Date: _____
Type: [ ] Colonoscopy [ ] EGD [ ] Other

Description	CPT Code	Unit Cost	Amount
Professional Fee (Endoscopist)	_____	$_____	$_____
Facility / Operating Room Fee	_____	$_____	$_____
Anesthesia Services	_____	$_____	$_____
Pathology / Lab Biopsy Fee	_____	$_____	$_____
Medical Supplies & Medication	_____	$_____	$_____

Subtotal: $_____
Insurance Paid: ($_____)

Total Due: $_____

Payment Instructions:

Please make checks payable to [Facility Name]. For billing inquiries, contact the billing office at [Phone Number] during business hours.

Note: This is a billing statement for medical services rendered.