[HOSPITAL NAME]

[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: [000000]
Date: [MM/DD/YYYY]

Patient Information:

[Patient Full Name]
[Patient ID / DOB]
[Patient Address]

Admission Details:

Admit Date: [MM/DD/YYYY]
Discharge Date: [MM/DD/YYYY]
Attending Surgeon: [Dr. Name]

Description of Service / Procedure	Date	Code (CPT/ICD)	Amount
Surgical Suite Use & Anesthesia	[Date]	[Code]	$0.00
Inpatient Room & Board (Private/Semi)	[Dates]	[Code]	$0.00
Post-Operative Pharmacy & Medications	[Range]	[Code]	$0.00
Laboratory & Diagnostic Imaging	[Date]	[Code]	$0.00

Description of Service / Procedure	Date	Code (CPT/ICD)	Amount
Medical Supplies & Implants	[Date]	[Code]	$0.00

Subtotal: $0.00

Insurance Adjustment/Covered: ($0.00)

Total Patient Responsibility: $0.00

Payment Terms: Due within 30 days of invoice date. Please make checks payable to [Hospital Name].

For billing inquiries, please contact the Financial Services Department at [Phone Number].