[HOSPITAL NAME]

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

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

Patient Information:
[Patient Full Name]
[Patient ID / DOB]
[Address]
Surgery Details:
Procedure: [Procedure Name]
Date of Surgery: [MM/DD/YYYY]
Surgeon: [Dr. Name]

Billing Breakdown

Description	Code (CPT/HCPCS)	Amount
Operating Room Fee	[Code]	$0.00
Surgeon Professional Fee	[Code]	$0.00
Anesthesia Services	[Code]	$0.00
Inpatient Room & Board ([#] Nights)	[Code]	$0.00

Description	Code (CPT/HCPCS)	Amount
Medical Supplies & Implants	[Code]	$0.00
Laboratory / Diagnostic Imaging	[Code]	$0.00
Post-Operative Pharmacy/Medications	[Code]	$0.00

Total Gross Charges: $0.00
Insurance Adjustments: ($0.00)
Insurance Paid: ($0.00)

Patient Responsibility: $0.00

Please include the invoice number with your payment.

Thank you for choosing [Hospital Name] for your care.