SPINAL SURGERY CENTER

[Medical Group Name]
[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE # [0000]
DATE: [MM/DD/YYYY]
TAX ID: [00-0000000]

BILL TO:

[Patient Name]
[Patient Address]
[Patient Phone]
DOB: [MM/DD/YYYY]

PROCEDURE DETAILS:

Surgeon: Dr. [Name]
Date of Service: [MM/DD/YYYY]
Facility: [Hospital Name]
Authorization #: [Number]

CPT Code	Description of Service / Spinal Level	Units	Unit Price	Total
[00000]	[Primary Procedure: e.g., Anterior Cervical Discectomy]	[0]	$0.00	$0.00
[00000]	[Instrumentation / Grafting]	[0]	$0.00	$0.00
[00000]	[Assistant Surgeon Fee]	[0]	$0.00	$0.00

CPT Code	Description of Service / Spinal Level	Units	Unit Price	Total
[00000]	[Anesthesia Services]	[0]	$0.00	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Amount Paid: $0.00

Balance Due: $0.00

Notes: Please include invoice number on all checks. Payment is due within 30 days of billing date.

ICD-10 Diagnoses: [Diagnosis Code(s)]