PEDIATRIC CARE

[Practice Name]
[NPI Number]
[Address]
[Phone Number]

INVOICE

Date: [Date]
Invoice #: [0000]

Patient Information:

[Patient Full Name]
DOB: [MM/DD/YYYY]
Parent/Guardian: [Name]

Billing Details:

Insurance: [Provider Name]
Policy ID: [ID Number]
Place of Service: 02 (Telehealth)

Date of Service	CPT/HCPCS Code	Modifier	Description	Charge
[Date]	[99213]	[95/GT]	Telemedicine Visit - Established Patient	$0.00
[Date]	[Code]		[Additional Services/Supplies]	$0.00

Subtotal: $0.00

Insurance Adjustment: ($0.00)

Total Due: $0.00

Provider Signature: _____

Note: This telehealth service was conducted via a HIPAA-compliant audiovisual platform.