[Practice Name]

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

VIRTUAL VISIT / TELEHEALTH

INVOICE

Invoice #: [00000]
Date: [MM/DD/YYYY]
Service Date: [MM/DD/YYYY]

PATIENT:

[Patient Full Name]
[Patient Address]
[Patient DOB: MM/DD/YYYY]
[Patient ID/MRN]

BILLING TO:

[Insurance Provider Name]
[Policy Number]
[Group Number]

CPT/Service Code	Description of Service	Duration	Charges
[99213 / 99214]	Telemedicine Evaluation & Management	[00] Mins	$0.00

CPT/Service Code	Description of Service	Duration	Charges
[95 / GT]	Telehealth Synchronous Modifier	-	$0.00
[Misc Code]	[Other Service/Lab/Prescription Fee]	-	$0.00

Subtotal: $0.00
Insurance Paid: ($0.00)

Total Due: $0.00

Payment Instructions: Please remit payment within [30] days via the patient portal or by mail.

This document serves as an official medical invoice for your records. For questions regarding your virtual consultation, please contact our billing department at [Phone/Email].