Specialist Virtual Care

[Provider Name / Clinic Name]

[NPI Number / Tax ID]

[Provider Address / Contact Info]

INVOICE NUMBER

#00000

DATE OF SERVICE

[MM/DD/YYYY]

PATIENT INFORMATION

[Patient Full Name]

[Date of Birth]

[Policy / Member ID]

BILLING INFORMATION

[Payer Name / Insurance Co.]

[Claims Address]

[Platform: e.g., Zoom Health, Doxy.me]

CPT/HCPCS Code	Description of Service	Modifier	Units	Amount
99214	Telehealth Office Visit (Level 4)	95	1	$0.00
				$0.00
				$0.00

Subtotal: $0.00

Tax / Adjustments: $0.00
Total Due: $0.00

Notes: All virtual services provided via secure, HIPAA-compliant encrypted video communication. Place of Service (POS) Code 02 or 10 as applicable.

Payment Terms: Please remit payment within 30 days of invoice date.