INVOICE

[Physician/Practice Name]
[NPI Number]
[Address]
[Phone/Email]

INVOICE #: [000]
DATE: [MM/DD/YYYY]

BILL TO:

[Patient Name]
[Patient Address]
[Date of Birth]

INSURANCE INFO:

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

Service Date	CPT Code	Description (Telehealth)	Modifier	Amount
[Date]	[Code]	[Service Description]	[95/GT]	$0.00
[Date]	[Code]	[Service Description]	[95/GT]	$0.00

Subtotal: $0.00

Insurance Paid: ($0.00)

Total Balance Due: $0.00

Place of Service: 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's Home)

Notes: [Additional clinical notes or payment instructions]