[PRACTICE NAME]

[Provider Name, Credentials]
[NPI Number]
[Office Address]
[Phone Number] | [Email]

INVOICE

BILL TO

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

INVOICE DETAILS

Invoice #: [0000]
Date: [Month DD, YYYY]
Due Date: [Month DD, YYYY]

Date of Service	CPT Code	Description of Service	Amount
[Date]	[e.g., 90792]	Psychiatric Diagnostic Evaluation with Medical Services	$0.00
[Date]	[e.g., 90833]	Psychotherapy add-on (30 minutes)	$0.00

Subtotal $0.00
Insurance Adjustment ($0.00)
Total Amount Due $0.00

NOTES & PAYMENT INSTRUCTIONS

Please make checks payable to **[Practice Name]**. For electronic payments, use [Platform/Handle].
This document serves as an official receipt for insurance reimbursement purposes (Superbill).

Diagnosis Code (ICD-10): [Code]