DIAGNOSTIC INVOICE

Anatomic Pathology Services

Invoice #:

Date:

PROVIDER INFORMATION

Laboratory Name
Street Address City, State, Zip
Phone: (555) 000-0000
CLIA #:

REFERRING PHYSICIAN / CLIENT

Name:
Facility:
NPI #:

PATIENT INFORMATION

Name:
DOB:
Patient ID/MRN:

CASE DETAILS

Accession Number:
Date of Service:
Specimen Source:

CPTÂ® Code	Description of Services	Units	Unit Price	Total
	Surgical Pathology, gross and microscopic		$	$
	Special Stains / IHC		$	$
	Professional Component (PC)		$	$

Subtotal: $_____

Adjustments: $_____
Balance Due: $_____

Payment Terms: Net 30 days. Please include Accession Number with payment.

This document contains confidential health information protected by HIPAA regulations.