LABORATORY INVOICE

Clinical Chemistry Division

INVOICE #
DATE

PROVIDER / LABORATORY INFO
ORDERING PHYSICIAN
PATIENT INFORMATION

Name:

ID / DOB:

BILLING ADDRESS

Test Code	Description of Service / Panel	Unit Price	Total

Subtotal: $ _________
Insurance Adj: $ _________
Amount Due: $ _________

NOTES / CLINICAL INDICATIONS

Please make checks payable to the Laboratory Name listed above. Payment is due within 30 days of invoice date.

Confidential Medical Record: This document contains protected health information (PHI).