CLINICAL PATHOLOGY LABORATORY

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-9988

INVOICE

Invoice #: [_____]
Date: [_____]

PATIENT INFORMATION

Name: [_____]
ID/MRN: [_____]
DOB: [_____]

ORDERING PHYSICIAN

Name: Dr. [_____]
Clinic: [_____]
NPI: [_____]

Test Code	Description of Service / Laboratory Test	Date Collected	Amount
[_____]	[_____]	[_____]	$ 0.00
[_____]	[_____]	[_____]	$ 0.00
[_____]	[_____]	[_____]	$ 0.00

Subtotal: $ 0.00

Insurance Adjustment: ($ 0.00)
Total Balance Due: $ 0.00

Payment Terms: Net 30 days. Please make checks payable to "Clinical Pathology Laboratory".

This document contains confidential medical information protected by HIPAA. If you have questions regarding these diagnostic codes or results, please contact our billing department.