INVOICE

[Diagnostic Facility Name]
[Facility Address line 1]
[Facility Address line 2]

INVOICE #: [00000]
DATE: [MM/DD/YYYY]

PATIENT / BILL TO: [Patient Name] [Patient Address] [Phone Number]
REFERRAL DOCTOR: [Doctor Name] **CASE ID:** [Case Reference Number]

Service Code	Diagnostic Description	Unit Price	Amount
[Code 01]	[Diagnostic Test Name / Screening Description]	$0.00	$0.00
[Code 02]	[Diagnostic Test Name / Screening Description]	$0.00	$0.00
[Code 03]	[Lab Processing Fee / Facility Fee]	$0.00	$0.00

Subtotal: $0.00
Tax/Insurance Adj: $0.00

Total Balance Due: $0.00

Payment Terms: Payable upon receipt. Please include Invoice # with payment.

Notice: This document contains confidential medical billing information.