

# GENETIC TESTING LABORATORY

123 Science Park Drive, Suite 400  
Cambridge, MA 02139  
Phone: (555) 010-9876

## INVOICE

Invoice #: [0000]  
Date: [MM/DD/YYYY]  
Due Date: [MM/DD/YYYY]

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### BILL TO

[Ordering Physician/Clinic Name]  
[Facility Name]  
[Street Address]  
[City, State, Zip]

### PATIENT INFORMATION

Patient Name: [Name]  
DOB: [MM/DD/YYYY]  
Accession #: [000-000]  
Sample Type: [Blood/Saliva/Tissue]

| Test Code | Description / Panel Name                     | CPT Codes | Quantity | Unit Price | Total  |
|-----------|--|-----------|----------|------------|--------|
| [CODE-01] | [Exome Sequencing / Hereditary Cancer Panel] | [81400]   | 1        | \$0.00     | \$0.00 |
| [CODE-02] | [Bioinformatics Analysis Fee]                | [N/A]     | 1        | \$0.00     | \$0.00 |

Subtotal: \$0.00  
Tax: \$0.00

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**Total Amount: \$0.00**

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**Payment Terms:** Net 30. Please make checks payable to "Genetic Testing Laboratory".

**Note:** This testing was performed in a CLIA-certified and CAP-accredited facility. For billing inquiries, contact [billing@genlab-example.com](mailto:billing@genlab-example.com).