

# HEMATOLOGY CENTER

123 Medical Plaza, Lab Wing  
Phone: (555) 010-9988  
Email: billing@hematologylab.com

## INVOICE

Invoice #: \_\_\_\_\_  
Date: \_\_\_\_\_

### PATIENT INFORMATION

Name: \_\_\_\_\_  
ID: \_\_\_\_\_  
DOB: \_\_\_\_\_

### ORDERING PHYSICIAN

Dr. \_\_\_\_\_  
Facility: \_\_\_\_\_  
Ref #: \_\_\_\_\_

CPT Code	Test Description	Qty	Unit Price	Total
85025	Complete Blood Count (CBC) w/ Differential			
85060	Blood Smear, Peripheral; Interpretation			
85610	Prothrombin Time (PT)			
85045	Reticulocyte Count, Automated			

CPT Code	Test Description	Qty	Unit Price	Total
----------	------------------	-----	------------	-------

---

Subtotal: \$ \_\_\_\_\_  
Insurance Adj: (\$ \_\_\_\_\_)  
Balance Due: \$ \_\_\_\_\_

---

**Payment Terms:** Due upon receipt. Please make checks payable to "Hematology Center".

Lab reports are attached to this invoice. For clinical inquiries, contact the Laboratory Director.