

# IMMUNOLOGY DIAGNOSTICS LAB

123 Bio-Research Way, Suite 400  
Medical District, NY 10012  
Phone: (555) 010-8899

## INVOICE

Date: [Date]  
Invoice #: [00000]

### BILL TO:

[Client/Hospital Name]  
[Attn: Department]  
[Street Address]  
[City, State, Zip]

### PATIENT & SPECIMEN DETAILS:

Patient ID: [ID-000]  
Specimen ID: [SID-000]  
Collection Date: [Date]  
Ordering Physician: [Name]

Test Code	Diagnostic Description	Qty	Unit Price	Total
[CPT-001]	Antinuclear Antibody (ANA) Screen, IFA	1	\$0.00	\$0.00
[CPT-002]	Cytokine Panel (IL-1, IL-6, TNF-alpha)	1	\$0.00	\$0.00
[CPT-003]	T-Lymphocyte Subset Panel (CD3, CD4, CD8)	1	\$0.00	\$0.00

**Subtotal: \$0.00**  
**Tax (0%): \$0.00**  
**Amount Due: \$0.00**

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**Payment Terms:** Net 30 days. Please include the invoice number with your payment.

This document serves as an official request for payment for immunological laboratory services rendered. Results have been transmitted to the ordering physician.