

[Laboratory Name]
[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

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

BILL TO:

[Client/Physician Name]
[Facility Name]
[Address]

PATIENT INFO:

Name: [Patient Name]
DOB: [MM/DD/YYYY]
Accession #: [000000]

Test Code	Description	Collection Date	Unit Price
[T-701]	Comprehensive Drug Screening (Urine)	[MM/DD/YYYY]	\$0.00
[T-905]	Confirmatory LC-MS/MS Testing	[MM/DD/YYYY]	\$0.00
[S-102]	Specimen Handling Fee	-	\$0.00

Subtotal: \$0.00

Tax: \$0.00

Total Balance Due: \$0.00

Terms: Payment is due within 30 days. Please include the accession number with your remittance.

This document is for billing purposes only and does not contain clinical results.