URINALYSIS LABORATORY

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 010-8888

INVOICE

Invoice #: _____
Date: _____

PATIENT / BILL TO:

Name: _____
ID: _____
Address: _____

PROVIDER INFORMATION:

Ordering Physician: _____
Clinic Name: _____
Specimen ID: _____

CPT Code	Description of Service	Unit Price	Total
81001	Urinalysis, automated, with microscopy	$ _____	$ _____
81003	Urinalysis, automated, without microscopy	$ _____	$ _____
87086	Urine Culture, bacterial; quantitative	$ _____	$ _____
82570	Creatinine, urine	$ _____	$ _____

Subtotal: $ _____

Insurance Adjustment: ($ _____)

Total Balance Due: $ _____

Payment Terms: Please pay within 30 days of invoice date. Make checks payable to "Urinalysis Laboratory."

For billing inquiries, please contact our accounts department at billing@urlab.example.com