DIABETIC RETINOPATHY SCREENING

[Clinic Name]
[Clinic Address]
[Phone Number]

INVOICE

Date: _____
Invoice #: _____

PATIENT INFO:

[Patient Name]
[Patient ID / DOB]
[Address]

REFERRING PHYSICIAN:

[Doctor Name]
[NPI Number]

Service Description	CPT Code	Qty	Unit Price	Total
Fundus Photography (Both Eyes)	92250	1	$	$
Retinal Imaging / Digital Screening	92227	1	$	$
Interpretation & Report	-	1	$	$

Subtotal: $_____
Tax: $_____
Grand Total: $_____

Notes/Diagnosis Codes: ICD-10: E11.319 (Type 2 diabetes with unspecified diabetic retinopathy) / Other: _____

Payment is due within [Number] days. Thank you for your visit.