INVOICE

Low Vision Rehabilitation Services

Invoice #: _____

Date: _____

Provider Details:

Name: _____

NPI/Tax ID: _____

Address: _____

Phone: _____

Bill To:

Patient Name: _____

ID Number: _____

Address: _____

Date of Service	CPT/HCPCS Code	Description of Service/Device	Fee

Date of Service	CPT/HCPCS Code	Description of Service/Device	Fee

Subtotal: $ _____
Insurance Adjustment: $ _____

Total Amount Due: $ _____

Notes / Diagnosis Codes (ICD-10): _____

Payment Terms: Due upon receipt. Please make checks payable to the provider listed above.