VISION CARE INVOICE

Provider Name: _____

Tax ID/NPI: _____

Invoice #: _____

Date of Service: _____

Patient Information
Name:

DOB:

Policy ID:

Insurance Provider
Carrier:

Group #:

Authorization #:

Service/Product Code	Description	Quantity	Unit Price	Total
	Comprehensive Eye Exam			
	Frames			
	Lenses (Single/Bifocal/Trifocal)			
	Lens Coatings/Treatments			

Service/Product Code	Description	Quantity	Unit Price	Total
	Contact Lens Fitting			
	Other:			

Subtotal:

Insurance Coverage:

Patient Responsibility:

Amount Due:

Provider Signature

Thank you for choosing our vision care services.