ART CLINIC NAME

123 Medical Plaza, Suite 100
Fertility City, ST 12345
Phone: (555) 000-0000

INVOICE

[Invoice Number]
Date: [MM/DD/YYYY]

PATIENT INFORMATION **[Patient Full Name]**
[Patient ID / Case Number]
[Address Line 1]
[City, State, Zip]
CYCLE DETAILS Physician: [Doctor Name]
Cycle Type: [IVF/IUI/ICSI/FET]
Cycle Start: [Date]

Service Description	Code	Amount
Oocyte Retrieval / Egg Collection	58970	$0.00
Sperm Processing / Preparation	89260	$0.00
Intracytoplasmic Sperm Injection (ICSI)	89280	$0.00
Embryo Culture and Monitoring	89250	$0.00
Cryopreservation of Embryos	89258	$0.00

Subtotal: $0.00
Lab Fees: $0.00
Total Due: $0.00

Payment Terms: Payment is due within 30 days. Please include invoice number with your payment.

Note: Medications and external pharmacy costs are billed separately by the respective providers.