FERTILITY CLINIC

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

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION **Name:** _____
ID: _____
DOB: _____
BILLING DETAILS **Provider:** _____
Insurance: _____
Auth #: _____

CPT CODE	DIAGNOSTIC SERVICE DESCRIPTION	QTY	UNIT PRICE	AMOUNT
83001	FSH (Follicle Stimulating Hormone) Assay			
83002	LH (Luteinizing Hormone) Assay			
82670	Estradiol Level Test			
89320	Semen Analysis; volume, count, motility			
76856	Ultrasound, Pelvic (Non-OB), complete			

Subtotal: $ _____
Insurance Adj: $ _____
Balance Due: $ _____

NOTES / REMARKS

Please make checks payable to "Fertility Clinic". Payments are due within 30 days of the invoice date.

Thank you for choosing our center for your diagnostic needs.