FERTILITY CARE PHARMACY

123 Wellness Way, Suite 400
Medical District, ST 12345
Phone: (555) 010-8888

INVOICE

Date: _____
Invoice #: _____

PATIENT:
Name: _____
DOB: _____
Phone: _____

PRESCRIBER:
Clinic: _____
Physician: _____
NPI: _____

Medication & Strength	Qty	Days Supply	Unit Price	Total
(e.g. Gonal-f / Follistim)	____	____	$____	$____
(e.g. Cetrotide / Ganirelix)	____	____	$____	$____
(e.g. Menopur)	____	____	$____	$____
(e.g. Trigger / Ovidrel)	____	____	$____	$____
Ancillary Supplies (Needles/Sharps)	____	-	$____	$____

Subtotal: $_____
Insurance Adjustment: ($_____)
Shipping: $_____

Total Due: $_____

Note: Specialized fertility medications may require refrigeration. Please inspect contents immediately upon delivery. For clinical questions or injection support, please contact our 24/7 nursing line.

Pharmacist Signature: _____ Date: _____