IVF MEDICAL CLINIC

123 Fertility Way
Medical District, ST 12345
Phone: (555) 010-8888

Invoice #: _____

Date: _____

PATIENT INFO:

Name: _____
ID: _____
Address: _____

PHYSICIAN:

Dr. _____

Service Description	CPT Code	Qty	Unit Cost	Total
Initial Fertility Consultation	99204			
Ultrasound Transvaginal	76830			
Oocyte Retrieval / Egg Collection	58970			
Embryo Transfer	58974			
Laboratory Fees (ICSI/Culturing)	89280			
Cryopreservation (Storage)	89342			

Service Description	CPT Code	Qty	Unit Cost	Total

Subtotal: $_____

Insurance Adjustment: ($_____)

Balance Due: $_____

Payment Terms: Payment is due within 30 days. Please make checks payable to IVF Medical Clinic.

Note: This is a medical invoice for professional services rendered. Please retain for your tax and insurance records.