MALE FERTILITY CLINIC

[Clinic Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____

Date: _____

PATIENT INFORMATION:

Name: _____
DOB: _____
ID #: _____

REFERRING PHYSICIAN:

Name: _____
NPI: _____

Service Description (CPT Code)	Qty	Unit Price	Total
Semen Analysis, Basic (89320)			
Sperm Morphology (89322)			
Sperm DNA Fragmentation			
Hormone Panel (FSH, LH, Testosterone)			
Urological Consultation (99204)			

Service Description (CPT Code)	Qty	Unit Price	Total
Scrotal Ultrasound (76870)			

SUBTOTAL: $_____

INSURANCE ADJUSTMENT: ($_____)

TOTAL BALANCE DUE: $_____

Notes / Clinical Indications:

Payment is due within 30 days. Please make checks payable to "Male Fertility Clinic".

For billing inquiries, please contact the administration office at [Phone Number].