Reproductive Endocrinology & Infertility

[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: [00000]
Date: [MM/DD/YYYY]

Patient Information:

[Patient Full Name]
DOB: [MM/DD/YYYY]
ID: [Patient ID/Chart #]
[Patient Address]

Insurance Information:

Provider: [Insurance Name]
Policy #: [Policy ID]
Authorization: [Auth Code]

CPT Code	Description of Service / Procedure	Date of Service	Amount
[00000]	[e.g., Initial Fertility Consultation]	[MM/DD/YY]	$0.00
[00000]	[e.g., Transvaginal Ultrasound / Follicle Scan]	[MM/DD/YY]	$0.00
[00000]	[e.g., Estradiol (E2) Serum Lab]	[MM/DD/YY]	$0.00
[00000]	[e.g., IVF Cycle Management Fee]	[MM/DD/YY]	$0.00

Subtotal: $0.00

Insurance Adjustment: ($0.00)

Patient Co-pay/Co-insurance: $0.00

Total Balance Due: $0.00

Payment Terms: Please remit payment within 30 days. Make checks payable to [Clinic Name].

Diagnosis Codes (ICD-10): [N97.9, etc.]

For billing inquiries, please contact the financial coordinator at [Phone Number/Email].