[CLINIC/PROVIDER NAME]

[Street Address]
[City, State, Zip]
[Phone Number]
[NPI / Tax ID]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____

BILLING/INSURANCE

Provider: _____
Policy #: _____
Auth #: _____

CPT Code	Description of Neurological Service	Qty/Units	Unit Price	Total
99204/5	Comprehensive Neurological Consultation			
95816	Electroencephalogram (EEG)			
95910	Nerve Conduction Studies (1-2 studies)			

CPT Code	Description of Neurological Service	Qty/Units	Unit Price	Total
95909	Electromyography (EMG)			
96116	Neurobehavioral Status Exam			
	[Other Procedure/Supplies]			

Subtotal: $ _____
Insurance Adjustment: ($ _____)
Amount Due: $ _____

Payment Terms: Due within 30 days of invoice date. Please make checks payable to [Clinic Name].

Diagnosis Codes (ICD-10): _____