NEUROLOGY SPECIALIST

INVOICE

[Practice Name]
[Medical License Number]
[Street Address]
[City, State, Zip]
[Phone Number]

Date: [MM/DD/YYYY]
Invoice #: [0000]
Patient ID: [0000]

Patient Information:

[Patient Full Name]
[Patient Address]
[Contact Number]

Insurance Provider:

[Insurance Company Name]
Policy #: [00000000]
Group #: [00000000]

CPT Code	Description of Services	Date of Service	Amount
99204	Office Consultation (Neurological Evaluation)	[MM/DD/YY]	$0.00
95819	Electroencephalogram (EEG)	[MM/DD/YY]	$0.00
95910	Nerve Conduction Studies (1-2 Studies)	[MM/DD/YY]	$0.00

Subtotal: $0.00

Insurance Paid: ($0.00)

Total Balance Due: **$0.00**

Diagnosis Codes (ICD-10): [G40.909, R51.9, etc.]

Payment Instructions: Please make checks payable to [Practice Name]. Payments are due within 30 days of the invoice date.