NEUROLOGY CONSULTATION

[Practice Name / Physician Name]
[Medical License Number]
[Clinic Address]
[Phone Number]

Invoice #: _____
Date: _____
Patient ID: _____

BILL TO:
[Patient Full Name]
[Patient Address]
[Insurance Provider Name]
[Policy Number]

REFERRING PHYSICIAN:
[Referring Doctor Name]
[NPI Number]

CPT Code	Service Description	Date of Service	Amount
[99204/5]	Neurological Consultation - New Patient	[MM/DD/YY]	$0.00
[95819]	EEG - Diagnostic / Clinical	[MM/DD/YY]	$0.00
[95910]	Nerve Conduction Studies	[MM/DD/YY]	$0.00

Subtotal: $0.00

Insurance Adjustment: ($0.00)

TOTAL DUE: $0.00

Payment Terms: Due within 30 days. Please make checks payable to [Practice Name].

Notes: Diagnosis Code (ICD-10): _____