

CANCER CARE CLINIC

123 Oncology Way, Medical District
City, State, ZIP
Phone: (555) 010-9988

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
Address: _____

INSURANCE DETAILS

Provider: _____
Policy #: _____
Auth Code: _____

Date of Service	Description of Service / Procedure Code	Qty	Unit Price	Amount

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Subtotal: \$ _____
Insurance Coverage: - \$ _____
Co-pay / Deductible: \$ _____

Total Balance Due: \$ _____

NOTES & PAYMENT INSTRUCTIONS

Please include the invoice number with your payment. Checks should be made payable to "Cancer Care Clinic". For financial assistance or billing inquiries, please contact our Patient Advocacy office.

This document contains confidential medical billing information. Confidentiality is protected by law.