INVOICE

[Clinic/Hospital Name]
[Facility Address]
[Tax ID / Provider Number]

Invoice #: ____________
Date: ____________

Patient Information:
Name: ________________________
ID: __________________________
Address: ______________________
Session Details:
Date of Service: ______________
Ordering Physician: ___________
Treatment Cycle: ______________

CPT/HCPCS Code	Description of Service/Drug	Qty/Units	Unit Cost	Total
____________	Infusion Initial Hour (e.g., 96413)	____________	____________	____________
____________	Additional Hour(s) (e.g., 96415)	____________	____________	____________
____________	Chemotherapy Drug: ______________	____________	____________	____________
____________	Anti-emetics/Pre-medications	____________	____________	____________

CPT/HCPCS Code	Description of Service/Drug	Qty/Units	Unit Cost	Total
____________	Saline/Medical Supplies	____________	____________	____________

Subtotal: $__________

Insurance Coverage Estimate: ($__________)

Balance Due: $___________

Notes: ____

Payment Terms: Due upon receipt. Please make checks payable to [Clinic Name].