

# ONCOLOGY SPECIALIST CENTER

[Clinic Address Line 1]

[City, State, Zip]

Phone: [000-000-0000]

## INVOICE

INVOICE #  
DATE

### PATIENT INFORMATION

Name:

ID/MRN:

Address:

### REFERRING PHYSICIAN

Name:

NPI Number:

Clinic:

Date of Service	CPT/HCPCS Code	Description of Services	Unit Cost	Total
		Initial Oncology Consultation		
		Chemotherapy Administration Review		
		Diagnostic Report Interpretation		

<b>Date of Service</b>	<b>CPT/HCPCS Code</b>	<b>Description of Services</b>	<b>Unit Cost</b>	<b>Total</b>
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Subtotal: \$0.00  
Insurance Adjustments: (\$0.00)  
Total Amount Due: \$0.00

**DIAGNOSIS / ICD-10 CODES**

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Payment Terms: Due upon receipt. Please make checks payable to "Oncology Specialist Center".

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_