COMPREHENSIVE CANCER CENTER

123 Medical Oncology Way
Clinical Research District
Phone: (555) 010-8888

INVOICE

Date: ____________
Invoice #: ____________
Patient ID: ____________

BILL TO

____
____
____

INSURANCE PROVIDER

Carrier: ______________________
Policy #: ______________________
Group #: _______________________

Date of Service	CPT/HCPCS Code	Description of Services / Medications	Charges

Date of Service	CPT/HCPCS Code	Description of Services / Medications	Charges

Total Gross Charges: $ __________
Insurance Adjustments: ($ _________)
Insurance Paid: ($ _________)
Patient Responsibility: $ __________

Payment Terms: Due upon receipt. Please make checks payable to "Comprehensive Cancer Center".

Notice: This document may contain confidential health information protected by federal law. If you are not the intended recipient, please notify the sender immediately.