

Hematology & Oncology Associates

123 Medical Center Way
City, State, Zip Code
Phone: (555) 000-0000
Tax ID: 00-0000000

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

Patient Information:

Name: _____
ID: _____
DOB: _____

Billing To:

Insurance: _____
Policy #: _____
Group #: _____

Date of Service	CPT/HCPCS Code	Description (Infusion/Labs/Consult)	Qty	Unit Price	Total

Subtotal: \$ _____

Insurance Paid: (\$ _____)

Patient Balance: \$ _____

Diagnosis Codes (ICD-10): _____

Notes: Please include the invoice number with your payment. Checks should be made payable to Hematology & Oncology Associates.