

ONCOLOGY IMAGING CENTER

[Hospital Address Line 1]

[City, State, Zip]

Phone: (555) 000-0000

INVOICE

Invoice #: _____

Date: _____

PATIENT INFORMATION

Name: _____

ID: _____

DOB: _____

BILLING / INSURANCE

Provider: _____

Policy #: _____

Auth #: _____

CPT Code	Description of Service (Modality/Region)	Radiologist	Amount
_____	PET/CT Scan - _____	Dr. _____	\$ _____
_____	MRI with/without Contrast - _____	Dr. _____	\$ _____

CPT Code	Description of Service (Modality/Region)	Radiologist	Amount
_____	Radiopharmaceutical / Contrast Media	-	\$ _____
_____	Facility Fee / Professional Component	-	\$ _____

Subtotal: \$ _____
Insurance Adjustment: (\$ _____)
Patient Responsibility: \$ _____

Notes: Services rendered relate to oncological staging and diagnostic monitoring. Please include the invoice number with your payment.

Terms: Due upon receipt. All diagnostic reports are sent directly to the referring oncologist.