

# ONCOLOGY INFUSION CENTER

[Street Address]  
[City, State, Zip]  
Phone: (555) 000-0000

## INVOICE

Invoice #: \_\_\_\_\_  
Date: \_\_\_\_\_  
Account #: \_\_\_\_\_

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### PATIENT INFORMATION:

[Name]  
[Address]  
[City, State, Zip]  
DOB: \_\_\_\_\_

### BILLING TO:

[Insurance Provider / Primary Guarantor]  
[Policy ID / Group #]  
[Billing Address]

Date of Service	HCPCS/CPT Code	Description (Drug Name / Administration)	Qty/Units	Unit Price	Total

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Subtotal: \$0.00  
Insurance Adjustment: (\$0.00)  
Insurance Paid: (\$0.00)

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**Patient Responsibility: \$0.00**

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**Notes:** All chemotherapy and supportive care infusions are billed based on current Medicare/Private Insurance fee schedules. Please contact our billing office for payment plans or financial assistance inquiries.

NPI: \_\_\_\_\_ | Tax ID: \_\_\_\_\_