

# OUTPATIENT ONCOLOGY UNIT

[Hospital Name]  
[Department Address]  
[Phone Number]

## INVOICE

Invoice #: \_\_\_\_\_

Date: \_\_\_\_\_

### Patient Information:

Name: \_\_\_\_\_

ID: \_\_\_\_\_

DOB: \_\_\_\_\_

### Insurance Details:

Provider: \_\_\_\_\_

Policy #: \_\_\_\_\_

Authorization: \_\_\_\_\_

Service Date	CPT/HCPCS Code	Description (Chemotherapy/Infusion/Consult)	Qty/Units	Unit Price	Total

Service Date	CPT/HCPCS Code	Description (Chemotherapy/Infusion/Consult)	Qty/Units	Unit Price	Total
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Subtotal: \$ \_\_\_\_\_  
Insurance Adjustment: (\$ \_\_\_\_\_)  
Patient Copay: \$ \_\_\_\_\_

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**Amount Due: \$ \_\_\_\_\_**

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**Notes:** All payments are due within 30 days of the invoice date. Please include the invoice number on your check.

**Physician Name:** \_\_\_\_\_ **NPI:** \_\_\_\_\_