Radiation Oncology Department

[Hospital Name]
[Medical Center Address]
Phone: (555) 000-0000

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
Patient ID: _____
DOB: _____
Address: _____

BILLING/INSURANCE

Provider: _____
Policy #: _____
Referring Physician: _____
Authorization #: _____

Date of Service	CPT/HCPCS Code	Description of Procedure/Treatment	Qty/Units	Unit Cost	Total
		Radiation Treatment Delivery (Linear Accelerator)			
		Treatment Planning / Dosimetry			
		Radiation Physics Consultation			

Date of Service	CPT/HCPCS Code	Description of Procedure/Treatment	Qty/Units	Unit Cost	Total
		Portal Verification Film/Imaging			

Subtotal: $ _____
Insurance Adjustment: $ _____
Patient Responsibility: $ _____

Payment Terms: Due upon receipt. Please make checks payable to "[Hospital Name] Oncology".

Note: This invoice reflects professional and technical components of radiation therapy services. For billing inquiries, contact the Financial Office at (555) 000-0001.