

# SURGICAL ONCOLOGY SERVICES

[Facility Name]  
[Address Line 1]  
[City, State, Zip]

**Invoice #:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**Case ID:** \_\_\_\_\_

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## Patient Information:

[Name]  
[Date of Birth]  
[Patient ID]

## Provider Information:

Surgeon: [Name]  
Department: Oncology Surgery  
NPI Number: [Number]

CPT Code	Procedure/Service Description	Qty	Unit Cost	Total
[Code]	Primary Tumor Resection / Excision	1	\$ 0.00	\$ 0.00
[Code]	Sentinel Lymph Node Biopsy / Dissection	1	\$ 0.00	\$ 0.00
[Code]	Surgical Pathology Consultation	1	\$ 0.00	\$ 0.00
[Code]	Anesthesia Services - Oncology	1	\$ 0.00	\$ 0.00

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

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**Total Due: \$ 0.00**

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**Notes:** All oncology surgical procedures include standard post-operative follow-up for 90 days as per global billing periods.

Payment is due within 30 days. Please make checks payable to [Facility Name].