

INVOICE

Provider: [Hospice Facility/Physician Name]
[Address Line 1]
[City, State, Zip]
[Tax ID / NPI Number]

Invoice #: [00000]
Date: [MM/DD/YYYY]

BILL TO: [Patient Name / Guardian]
[Address Line 1]
[City, State, Zip]
[Insurance Policy ID]
PATIENT DETAILS: DOB: [MM/DD/YYYY]
Admission Date: [MM/DD/YYYY]
Diagnosis Code (ICD-10): [Code]

Service Date	HCPCS/CPT Code	Description of Geriatric Support Service	Qty/Hrs	Rate	Total
[Date]	[Code]	[Service Description]	[Unit]	\$0.00	\$0.00
[Date]	[Code]	[Service Description]	[Unit]	\$0.00	\$0.00
[Date]	[Code]	[Service Description]	[Unit]	\$0.00	\$0.00

Subtotal: \$0.00

Insurance Adjustment: (\$0.00)

Total Amount Due: \$0.00

Payment Terms: Due within [30] days. Please make checks payable to [Provider Name].

Notes: This invoice covers palliative and geriatric support services under hospice care guidelines. For billing inquiries, contact [Phone Number].