CARE INVOICE

[Facility/Provider Name]
[Address Line 1]
[Address Line 2]
[Tax ID/NPI]

INVOICE # [0000]
DATE: [MM/DD/YYYY]
DUE DATE: [MM/DD/YYYY]

BILL TO:

[Responsible Party Name]
[Address Line 1]
[Address Line 2]
[Phone Number]

PATIENT INFORMATION:

Name: [Patient Full Name]
Patient ID: [ID Number]
Care Period: [Start Date] - [End Date]

Description of Services / Supplies	Date	Qty/Units	Rate	Total
Skilled Nursing Care - Level [X]	[Date Range]	[0]	$0.00	$0.00
Therapy Services (PT/OT/ST)	[Date]	[0]	$0.00	$0.00
Medical Supplies & Sundries	[Date]	[0]	$0.00	$0.00
Pharmacy / Medication Admin	[Date Range]	[1]	$0.00	$0.00

Subtotal: $0.00
Insurance Adjustments: ($0.00)

Balance Due: $0.00

Please make checks payable to **[Facility Name]**.
For billing inquiries, please contact [Phone Number] or [Email].
Thank you for choosing our care services.