INVOICE

[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number]

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

PATIENT INFORMATION

[Patient Name]
[Patient ID/DOB]
[Address]
[Phone]

REFERRING PHYSICIAN

[Physician Name]
[NPI Number]
[Clinic/Hospital]

CPT Code	Description of Service	Site (Hip/Spine/Wrist)	Amount
[77080]	DXA Bone Density Study: Axial Skeleton	[Site]	$0.00
[77081]	DXA Bone Density Study: Peripheral	[Site]	$0.00
	Facility Fee / Interpretation Fee	-	$0.00

Subtotal: $0.00
Insurance Adjust: ($0.00)

Total Balance Due: $0.00

NOTES & INSTRUCTIONS

Please make checks payable to **[Clinic Name]**. For insurance inquiries or credit card payments, please contact the billing department at [Phone Number]. Results have been forwarded to your referring physician.