CARDIOVASCULAR IMAGING

[Facility/Provider Name]
[Street Address]
[City, State, Zip]
[NPI Number]

INVOICE NUMBER

#00000

DATE

[MM/DD/YYYY]

PATIENT INFORMATION

[Patient Name]
[Date of Birth]
[Patient ID / Case Number]
[Referring Physician]

BILLING TO

[Payer/Insurance Name]
[Policy Number]
[Billing Address]

CPT Code	Description of Imaging Service	Qty	Unit Cost	Total
93306	Echocardiography, Transthoracic, Complete	1	$0.00	$0.00
93000	Electrocardiogram (ECG), Routine	1	$0.00	$0.00
[Code]	[Service Description]	1	$0.00	$0.00

Subtotal: $0.00
Tax/Adjustment: $0.00
Total Due: $0.00

Notes: Professional medical services for diagnostic cardiovascular imaging. Please include invoice number with payment.

Thank you for your business.