INVOICE

[Medical Facility 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]
[Patient Address]

BILLING TO:

[Insurance Provider / Self]
[Policy Number]
[Billing Address]

CPT Code	Description of CT Service	Qty	Unit Price	Amount
[00000]	CT Scan: [Region of Interest] - [With/Without Contrast]	1	$0.00	$0.00
[00000]	Radiologist Interpretation Fee	1	$0.00	$0.00
[00000]	Contrast Media / Supplies	1	$0.00	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Balance Due: $0.00

Ordering Physician: [Doctor Name]

Notes: Please include the invoice number with your payment. Payments are accepted via check, credit card, or online portal.