INVOICE

Facility Name: _____

Address: _____

Phone: _____

Invoice #: _____

Date: _____

PATIENT INFORMATION

Name: _____

ID/DOB: _____

Referring Physician: _____

BILLING INFORMATION

Payer: _____

Policy/ID: _____

Auth #: _____

CPT Code	Description of Procedure	Units	Unit Price	Total
_____	Fluoroscopy Guidance	____	$ _____	$ _____
_____	Contrast Material / Supplies	____	$ _____	$ _____
_____	Professional Component	____	$ _____	$ _____

CPT Code	Description of Procedure	Units	Unit Price	Total

Subtotal: $ _____
Tax/Fees: $ _____
Total Due: $ _____

Payment Terms: Net 30 days. Please include the invoice number with your payment.

This document is for medical billing purposes for Fluoroscopy Imaging Services.