CITY GENERAL HOSPITAL

Department of Radiology & Imaging
123 Medical Plaza, Health City
Phone: (555) 010-9988

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
Patient ID: _____
DOB: _____

REFERRAL DETAILS

Referring Physician: _____
Order Number: _____
Insurance Provider: _____

Service Date	Procedure Code / Description	Qty	Unit Price	Total

Subtotal: $ _____
Insurance Adjustment: - $ _____
Amount Due: $ _____

Payment Terms: Due within 30 days of invoice date.

Please make checks payable to *City General Hospital*. Include Patient ID on the check memo.

For billing inquiries, please contact the Radiology Billing Office at (555) 010-9999.