INTERVENTIONAL RADIOLOGY DEPT.

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

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____

PROCEDURE DETAILS

Referring MD: _____
Radiologist: _____
Access Site: _____

CPT Code	Description of Service / Supplies	Qty	Unit Price	Amount
_____	Procedure Charge: _____	____	$ _____	$ _____
_____	Imaging Guidance (Fluoroscopy/US/CT)	____	$ _____	$ _____
_____	Catheter / Stent / Embolic Materials	____	$ _____	$ _____

CPT Code	Description of Service / Supplies	Qty	Unit Price	Amount
_____	Contrast Media / Medications	____	$ _____	$ _____
_____	Recovery Room / Nursing Services	____	$ _____	$ _____

Subtotal: $ _____
Insurance Adjustments: ($ _____)
TOTAL DUE: $ _____

Payment Terms: Due within 30 days. Please include Invoice # on your check.

Note: Professional fees and facility fees may be billed separately. This is a medical billing document for Interventional Radiology services rendered.