PROVIDER INFORMATION

MRA INVOICE

PATIENT NAME
DATE OF BIRTH
REFERRING PHYSICIAN
INVOICE NUMBER
DATE OF SERVICE
PAYMENT STATUS

CPT Code	Description of Service	Amount
	MRA Head (Non-Contrast)	
	MRA Neck (With/Without Contrast)	
	Contrast Media / Radiopharmaceutical	
	Facility / Administrative Fee	

TOTAL DUE:

CLINICAL INDICATIONS / NOTES

This is a professional billing statement for Magnetic Resonance Angiography services rendered.