MRI SERVICES INVOICE

[Imaging Center Name]
[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE #: _____
DATE: _____
ORDER ID: _____

PATIENT INFORMATION

Name: _____
DOB: _____
ID: _____

REFERRING PHYSICIAN

Name: _____
NPI: _____
Clinic: _____

CPT Code	Description of Procedure	Units	Unit Price	Total
_____	MRI _____	_____	$ _____	$ _____
_____	Contrast Material (if applicable)	_____	$ _____	$ _____
_____	Radiology Professional Reading	_____	$ _____	$ _____

Subtotal: $ _____
Insurance Adjustment: ($ _____)
Amount Due: $ _____

Payment Terms: Due within 30 days. Please include Invoice # with payment.

Notice: This document contains confidential medical information. For billing inquiries, contact the billing department at [Phone Number].