NUCLEAR MEDICINE INVOICE

Facility Name
Department of Radiology

Invoice #: _____
Date: _____

PATIENT INFORMATION
Name: _____
ID/MRN: _____
DOB: _____
REFERRING PHYSICIAN
Name: _____
NPI: _____

CPT Code	Description of Service / Radiopharmaceutical	Dosage (mCi)	Amount

Subtotal: $_____
Insurance Adjustment: $_____

Total Balance Due: $_____

Payment Terms: Due within 30 days. Please include Invoice Number on remittance.

Nuclear Regulatory Commission License #: _____