[Facility Name]

[Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

ORDER DETAILS

Referring Physician: _____
Order Date: _____
Insurance Provider: _____

Service Code (CPT)	Description of Procedure	Qty	Unit Price	Total

Subtotal: $0.00
Insurance Adjustment: ($0.00)

Copay/Deductible: $0.00

Total Amount Due: $0.00

Notes: Please include the invoice number with your payment. Payment is due within 30 days.

NPI Number: _____ | Tax ID: _____