PET SCAN INVOICE

Positron Emission Tomography Department

Invoice # _____

Date _____

PATIENT INFORMATION

Name:

DOB:

ID:

FACILITY INFORMATION

Clinic Name:

Provider NPI:

Phone:

CPT Code	Description of Procedure / Radiopharmaceutical	Qty	Unit Cost	Total
78815	PET/CT Skull Base to Mid-Thigh			
A9552	Fluorodeoxyglucose F18 (FDG) Diagnostic			
	Other:			
	Professional Reading Fee			

Subtotal: $_____

Insurance Adjustment: ($_____)

Total Amount Due: $_____

Please make checks payable to the facility listed above.

Payment is due within 30 days of the invoice date.