INVOICE

[Practice Name]
[Street Address]
[City, State, Zip]
[Phone] | [Email]

Invoice #: [0000]
Date: [Date]
Due Date: [Date]

BILL TO:

[Patient Name]
[Patient Address]
[City, State, Zip]
[Insurance ID (if applicable)]

REFERRING PHYSICIAN:

[Physician Name]
[NPI Number]

Service Date	CPT Code	Description of Imaging Procedure	Amount
[Date]	[Code]	[e.g., MRI Lumbar Spine w/o Contrast]	$0.00
[Date]	[Code]	[e.g., Radiologist Reading Fee]	$0.00

Subtotal: $0.00

Insurance Adjustment: ($0.00)

Total Balance Due: $0.00

Payment Instructions: Please make checks payable to [Practice Name]. For credit card payments, call [Phone Number].

This is a formal request for payment for professional medical imaging services rendered.