

**LAB LOGO**

**Diagnostic Laboratory Services Inc.**

123 Medical Plaza, Health City

Phone: (555) 010-8888

Email: [billing@diaglab.example](mailto:billing@diaglab.example)

# INVOICE

Invoice #: \_\_\_\_\_

Date: \_\_\_\_\_

Due Date: \_\_\_\_\_

---

PATIENT / BILL TO:

Name: \_\_\_\_\_

ID: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

REFERRING PHYSICIAN:

Dr. \_\_\_\_\_

Clinic: \_\_\_\_\_

NPI/License: \_\_\_\_\_

Requisition #: \_\_\_\_\_

Test Code	Description of Service / Laboratory Test	Date of Service	Price
-----------	------------------------------------------	-----------------	-------


Subtotal: \$ \_\_\_\_\_  
Insurance Adj: (\$ \_\_\_\_\_)  
Balance Due: \$ \_\_\_\_\_

---

**Payment Terms:** Please make checks payable to "Diagnostic Laboratory Services Inc."  
For online payments, visit: [www.diaglab.example/pay](http://www.diaglab.example/pay)  
*Note: Results are released to the referring physician unless otherwise requested.*