Internal Medicine Associates

123 Medical Plaza, Suite 400
City, State, Zip
Phone: (555) 010-9988

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION:

Name: _____
ID: _____
DOB: _____

INSURANCE PROVIDER:

Carrier: _____
Policy #: _____
Group #: _____

Date of Service	CPT / HCPCS Code	Description of Services	Amount

Total Charges: $ _____
Insurance Paid: $ _____
Patient Copay/Deductible: $ _____

TOTAL AMOUNT DUE: $ _____

Provider: _____ **NPI:** _____

Please make checks payable to "Internal Medicine Associates". Payments are due within 30 days of invoice date.