

OPHTHALMOLOGY CARE

[Clinic Address Line 1]
[City, State, Zip]
Phone: (555) 000-0000

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

PROVIDER DETAILS

Dr. _____
NPI: _____
Tax ID: _____

Service Code / CPT	Description of Eye Service	Qty	Unit Price	Total
92014	Comprehensive Eye Exam (Established)	1	\$	\$
92025	Computerized Corneal Topography	1	\$	\$
92133	Scanning Laser (OCT) - Optic Nerve	1	\$	\$
	Other: _____		\$	\$

Subtotal: \$ _____

Insurance Adjustment: (\$ _____)

Copay/Paid: (\$ _____)

Total Amount Due: \$ _____

Notes: All payments are due within 30 days. Please include the invoice number on your check.

This is a formal billing document for ophthalmic medical services.