OUTPATIENT MEDICAL FACILITY

123 Medical Plaza, Suite 100
Healthcare City, ST 12345
Phone: (555) 000-0000

INVOICE

Invoice #: _____
Date: _____
Account #: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Address: _____
Phone: _____

INSURANCE INFORMATION

Provider: _____
Policy #: _____
Group #: _____
Auth #: _____

Date of Service	CPT/HCPCS Code	Description of Services/Supplies	Charges

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Total Charges: $ _____

Insurance Adjustment: $ _____

Insurance Paid: $ _____

Patient Co-pay/Deductible: $ _____

TOTAL AMOUNT DUE: $ _____

Please make checks payable to **Outpatient Medical Facility**.

Payments are due within 30 days of the invoice date. For billing inquiries, call (555) 000-0000.

Thank you for choosing our facility for your healthcare needs.