

INVOICE

Clinic:

Provider:

NPI/Tax ID:

Invoice #:

Date:

PATIENT INFORMATION:

Name:

ID/DOB:

Address:

INSURANCE/PAYOR:

Provider:

Policy #:

Auth #:

Date of Service	CPT Code / Description	Units	Rate	Amount

Subtotal:

Insurance Paid:

Co-pay/Deductible:

Balance Due:

Diagnosis (ICD-10):

Notes:

Thank you for choosing our practice for your rehabilitation.