MEDICAL PRACTICE NAME

123 Healthcare Ave, Suite 100
City, State, Zip Code
Phone: (555) 000-0000
NPI: 0000000000 | Tax ID: 00-0000000

INVOICE

Invoice #: ___________
Date: ___________
Due Date: ___________

PATIENT INFORMATION

Name: ________________________
DOB: _________________________
ID #: _________________________
Address: ______________________

INSURANCE INFORMATION

Carrier: _______________________
Policy #: _______________________
Group #: _______________________
Auth #: ________________________

Date of Service	CPT / HCPCS Code	Description of Service	Units	Charges

Total Charges: $ _________
Insurance Paid: $ _________
Patient Responsibility: $ _________

Amount Due: $ _________

NOTES & INSTRUCTIONS

Please make checks payable to **[Practice Name]**. For billing inquiries, contact our office during business hours. Payments are due within 30 days of the invoice date.