URGENT CARE CENTER

[Facility Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

Date: [Date]
Invoice #: [00000]

PATIENT INFORMATION:

[Patient Name]
[Patient Address]
[Date of Birth]

INSURANCE DETAILS:

[Provider Name]
ID: [Policy Number]
Group: [Group Number]

Service Code	Description of Service	Qty	Unit Cost	Total
[99214]	Office Visit - Level [X]	1	$[0.00]	$[0.00]
[CPT Code]	[Diagnostic/Lab Service]	1	$[0.00]	$[0.00]
[CPT Code]	[Procedure/Medication]	1	$[0.00]	$[0.00]

Subtotal: $[0.00]

Insurance Adjustment: - $[0.00]

Copay Paid: - $[0.00]

Total Balance Due: $[0.00]

Payment Terms: Due upon receipt. Please include invoice number with payment.

Provider NPI: [0000000000] | **Tax ID:** [00-0000000]