MEDICAL COURIER INVOICE

[Courier Company Name]
[Address Line 1]
[Phone Number] | [Email]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

BILL TO:

[Client/Facility Name]
[Billing Address]
[City, State, Zip]
Attn: Accounts Payable

PAYMENT TERMS:

[Net 30 / Due on Receipt]
Route Type: [Stat / Scheduled / On-Demand]

Service Date	Log ID / Ref #	Specimen/Item Type	Pickup/Dropoff Points	Rate	Amount
[Date]	[#]	[e.g., Blood/Pathology]	[Facility A to Lab B]	$0.00	$0.00
[Date]	[#]	[e.g., Pharma/Urgent]	[Pharmacy to Residence]	$0.00	$0.00
			Fuel Surcharge	[%]	$0.00

Subtotal: $0.00
Tax/Other Fees: $0.00
Total Amount Due: $0.00

Notes: All medical deliveries handled in compliance with HIPAA and OSHA safety standards. Temperature control maintained where applicable.

Payment Instructions: Please make checks payable to [Company Name] or pay via [Direct Deposit Details].