Allergy & Immunology Associates

123 Medical Plaza, Suite 400
Phone: (555) 010-8899
Email: billing@allergyclinic.example

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION:

Name: _____
DOB: _____
ID: _____

INSURANCE DETAILS:

Provider: _____
Policy #: _____
Auth #: _____

CPT Code	Description of Service / Test	Qty	Unit Cost	Total
95004	Percutaneous Skin Allergy Test (Scratch)	____	$____	$____
95117	Allergy Injection (Immunotherapy)	____	$____	$____
99213	Office Visit - Established Patient	____	$____	$____
95070	Inhalation Bronchial Challenge Testing	____	$____	$____

CPT Code	Description of Service / Test	Qty	Unit Cost	Total
	Other: _____	____	$____	$____

Subtotal: $_____

Insurance Adjustment: ($_____)

Co-pay Paid: ($_____)

Total Balance Due: $_____

Notes: _____

Please make all checks payable to Allergy & Immunology Associates. Payment is due within 30 days of service.