INVOICE

Endocrinology & Metabolism Specialists

Invoice #: _____

Date: _____

Provider Information:

Dr. _____

NPI Number: _____

Clinic Address: _____

Phone: _____

Patient Information:

Name: _____

DOB: _____

Patient ID: _____

Insurance: _____

Service Date	CPT/Code	Description of Service	Amount
/ / 20__	99214	Office Visit - Established Patient	$ _____

Service Date	CPT/Code	Description of Service	Amount
/ / 20__	82947	Glucose; quantitative, blood (Post-Prandial)	$ _____
/ / 20__	83036	Hemoglobin; Glycosylated (A1C)	$ _____
/ / 20__	84439	Thyroid Free T4	$ _____
/ / 20__		Other: _____	$ _____

Subtotal: $ _____

Insurance Adjustment: ($ _____)

Copay/Paid: ($ _____)

Total Balance Due: $ _____

Notes / Clinical Indications:

ICD-10 Codes: _____

Payment is due within 30 days. Please make checks payable to the clinic name listed above.