NEPHROLOGY SPECIALIST CARE

[Clinic Street Address]
[City, State, Zip]
Phone: (555) 000-0000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
ID: _____
Address: _____

PROVIDER & REFERRING MD

Attending: Dr. _____
NPI: _____
Referring: _____

Service Date	CPT/Code	Description of Treatment/Service	Amount
		Consultation / Evaluation / Management	$ 0.00
		Hemodialysis Session / Maintenance	$ 0.00
		Laboratory Tests (Creatinine, BUN, GFR)	$ 0.00
		Ultrasound - Renal/Bladder	$ 0.00

Service Date	CPT/Code	Description of Treatment/Service	Amount
		Medication / Injections (EPO, Vitamin D)	$ 0.00

Subtotal: $ 0.00
Insurance Adjustment: ($ 0.00)
Total Due: $ 0.00

Diagnosis Codes (ICD-10): _____

Payment is due within 30 days. Please make checks payable to Nephrology Specialist Care.