OBSTETRICS & GYNECOLOGY

[Clinic Name]
[Address Line 1]
[Phone Number]

Invoice #: _____
Date: _____
Due Date: _____

PATIENT BILL TO:

[Patient Name]
[Patient ID / DOB]
[Address]
[Insurance Provider]

PROVIDER INFO:

Physician: [Doctor's Name]
NPI Number: [Number]
Facility: [Hospital/Clinic Name]

Service Date	Description / CPT Code	Qty	Unit Price	Total
	Prenatal Care Visit (CPT: 99213)			
	Ultrasound, Pelvic (CPT: 76856)			
	Lab Work / Screening			

Subtotal: $0.00
Insurance Paid: $0.00

Patient Balance: $0.00

Notes: Please include the invoice number with your payment. Checks payable to [Clinic Name].

Confidential Medical Billing Document