ONCOLOGY TREATMENT CENTER

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

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____
ID: _____
DOB: _____

BILLING DETAILS

Insurance: _____
Policy #: _____
Provider: _____

Date of Service	Description of Service / Medication	HCPCS/CPT	Qty	Unit Cost	Total
	Chemotherapy Infusion - Initial Hour				
	Chemotherapy Drug: _____				
	Oncology Physician Consultation				
	Laboratory Services (CBC/Comprehensive)				

Date of Service	Description of Service / Medication	HCPCS/CPT	Qty	Unit Cost	Total

Subtotal: $_____
Insurance Adjustment: ($_____)
Co-pay / Deductible: $_____
Total Amount Due: $_____

Notes: Payments are due within 30 days of the invoice date. Please make checks payable to "Oncology Treatment Center". For billing inquiries, contact the Patient Finance Office.