PULMONOLOGY & RESPIRATORY CARE

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

INVOICE

Invoice #: _____
Date: _____

PATIENT INFORMATION

Name: _____
DOB: _____
Patient ID: _____

REFERRING PHYSICIAN

Name: _____
NPI #: _____

CPT Code	Diagnostic Service / Procedure	Unit Cost	Amount
94010	Spirometry (Pre/Post Bronchodilator)	$	$
94060	Bronchospasm Evaluation	$	$
94726	Plethysmography (Lung Volumes)	$	$
94729	DLCO (Diffusing Capacity)	$	$
94621	CPET (Cardiopulmonary Exercise Test)	$	$

CPT Code	Diagnostic Service / Procedure	Unit Cost	Amount

Subtotal: $_____
Insurance Adj: $_____

Total Due: $_____

DIAGNOSTIC NOTES / ICD-10 CODES

Payment is due within 30 days. Please include invoice number on checks.
Specialist Signature: _____ *Date:* _____