DERMATOLOGY CLINIC NAME

123 Medical Plaza, Suite 400
Healthcare City, ST 12345
Phone: (555) 000-0000
Tax ID / NPI: 00-0000000

INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

PATIENT INFORMATION

[Patient Full Name]
[Address Line 1]
[City, State, Zip]
DOB: [MM/DD/YYYY]

INSURANCE INFORMATION

Carrier: [Provider Name]
Policy #: [ID Number]
Group #: [Group ID]
Authorization: [Auth #]

Date of Service	CPT / HCPCS	Description of Procedure/Service	Units	Charge
[Date]	[99213]	Office Visit - Established Patient	1	$0.00
[Date]	[11102]	Tangential Biopsy of Skin (Single Lesion)	1	$0.00
[Date]	[88305]	Pathology / Tissue Examination	1	$0.00

Subtotal: $0.00
Insurance Adjustment: ($0.00)
Amount Paid: ($0.00)
Total Balance Due: $0.00

Diagnosis Codes (ICD-10): [Code 1], [Code 2], [Code 3]

Notes: Please include the invoice number with your payment. Checks should be made payable to [Dermatology Clinic Name]. For billing inquiries, contact the billing office at (555) 000-0001.