

EMS INVOICE

Agency Name
123 Emergency Lane
City, State, Zip

Phone: (555) 000-0000
Email: billing@emsagency.org

PATIENT INFORMATION:

Name: _____
Address: _____
DOB: _____
Incident #: _____
Invoice Date: _____
Due Date: _____
Account #: _____
Run Date: _____

Service Description	Code	Qty/Miles	Amount
ALS/BLS Base Rate	_____	_____	\$ _____
Mileage (Loaded)	A0425	_____	\$ _____
Oxygen / Supplies	_____	_____	\$ _____
Specialized Care / Meds	_____	_____	\$ _____

Subtotal: \$ _____

Insurance Adjustment: (\$ _____)

Total Balance Due: \$ _____

Payment Instructions: Please make checks payable to Agency Name. For credit card payments, visit our website or call our billing office.

Notice: This invoice represents services rendered for emergency medical transport and care. If you have insurance, please ensure your provider has been notified.