MEDICAL INVOICE

[Practice/Clinic Name]
[NPI Number]
[Address Line 1]
[City, State, Zip]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

PATIENT INFORMATION

[Patient Name]
DOB: [MM/DD/YYYY]
ID: [Patient ID/Chart #]
[Address]

INSURANCE PROVIDER

[Insurance Company Name]
Policy #: [Policy Number]
Group #: [Group Number]
Auth #: [Prior Auth if applicable]

Date of Service	CPT/HCPCS Code	Description	Units	Charges
[Date]	[Code]	[Description of Procedure/Consultation]	[1]	$[0.00]
[Date]	[Code]	[Description of Supplies/Tests]	[1]	$[0.00]

Total Charges: $[0.00]

Insurance Adjustments: ($[0.00])

Insurance Paid: ($[0.00])

Patient Responsibility: ($[0.00])

Total Amount Due: $[0.00]

Notes: Please include the invoice number with your payment. For billing inquiries, contact [Phone Number] or [Email].

ICD-10 Codes: [Diagnosis Codes]