INVOICE

PA Name: _____
NPI Number: _____
License #: _____

Date: _____
Invoice #: _____

Billing To:

Facility/Clinic Name
Address Line 1
City, State, Zip

Patient Info (if applicable):

Patient ID: _____
DOS: _____

CPT/HCPCS Code	Description of Services	Units/Hrs	Rate	Amount

Subtotal: $_____
Tax: $_____

Total Due: $_____

Payment Instructions:
Please make checks payable to: _____
Tax ID / EIN: _____
Terms: Net 30