[Healthcare Provider Name]

[Facility Address Line 1]
[City, State, Zip Code]
Phone: (000) 000-0000
NPI: [0000000000]

INVOICE

Invoice #: [00001]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

PATIENT INFORMATION

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

INSURANCE INFORMATION

[Insurance Carrier Name]
Policy #: [Policy Number]
Group #: [Group Number]
Auth #: [Prior Authorization]

Date of Service	CPT/HCPCS Code	Description of Service	Qty	Unit Cost	Total
[MM/DD/YY]	[99213]	[Office Visit - Level 3]	[1]	[$0.00]	[$0.00]

Date of Service	CPT/HCPCS Code	Description of Service	Qty	Unit Cost	Total
[MM/DD/YY]	[XXXXX]	[Diagnostic Procedure]	[1]	[$0.00]	[$0.00]

Subtotal: $0.00
Insurance Paid: ($0.00)
Adjustments: ($0.00)

Patient Responsibility: $0.00

Payment Terms: Please make checks payable to [Healthcare Provider Name]. Payments are due within 30 days of the invoice date.

Notes: For billing inquiries, please contact our billing department at (000) 000-0000 or email [email@example.com].