[Medical Practice Name]

[Street Address]
[City, State, Zip]
Phone: (000) 000-0000
Tax ID: 00-0000000

INVOICE

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

PATIENT INFORMATION

Name: [Patient Full Name]
ID: [Patient Account #]
DOB: [MM/DD/YYYY]

INSURANCE INFORMATION

Provider: [Insurance Company Name]
Policy #: [Member ID]
Group #: [Group Number]

Date of Service	CPT Code	Description of Service	Amount
[MM/DD/YYYY]	[00000]	[Procedure/Consultation Description]	$0.00
[MM/DD/YYYY]	[00000]	[Lab Work/Diagnostic Test]	$0.00

Subtotal: $0.00
Insurance Adjustment: -$0.00
Insurance Paid: -$0.00

Patient Responsibility: $0.00

For billing inquiries, please contact our business office at (000) 000-0000.

Confidential Medical Document