ADVANCED MEDICAL SYSTEMS

Support & Engineering Division
123 MedTech Blvd, Suite 400
San Francisco, CA 94107

INVOICE

Invoice #: [INV-0000]
Date: [Date]
Due Date: [Date]

BILL TO

[Client Hospital/Clinic Name]
[Department Name]
[Street Address]
[City, State, Zip]

SYSTEM INFORMATION

System ID: [ID-NUMBER]
Software Ver: [Version Number]
Service Plan: [Plan Type]

Description of Service / Hardware	Code	Qty/Hrs	Unit Price	Amount
[Tier 3 Remote Diagnostic Support]	[S-104]	[0.00]	$[0.00]	$[0.00]
[On-Site Calibration & Maintenance]	[M-202]	[0.00]	$[0.00]	$[0.00]

Description of Service / Hardware	Code	Qty/Hrs	Unit Price	Amount
[Hardware Component Replacement: Sensor A1]	[P-900]	[0.00]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax (0%): $[0.00]
Total Amount: $[0.00]

Payment Terms: Net 30. Please make checks payable to "Advanced Medical Systems".

Note: Technical support logs for this billing period are available upon request via the provider portal.