**Provider:**
**Address:**
**Phone:** **Email:**
**NPI Number:** **Tax ID / EIN:**
**State License #:**

# REIMBURSEMENT CLAIM INVOICE

**Invoice No:**
**Date:**

## PATIENT INFORMATION

**Patient Name:**
**Date of Birth:**
**Address:**
**Phone:**

## INSURANCE INFORMATION

**Insurance Co:**
**Policy ID:**
**Group Number:**
**Insured Name:**

| DATE OF SERVICE | CPT CODE | ICD-10 CODE | DESCRIPTION OF CHIROPRACTIC SERVICE / MODALITY | UNITS | CHARGES ($) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | |
|---|---|
| **Total Charges** | |
| **Amount Paid by Patient** | |
| **Balance Outstanding** | |

Authorized Practitioner Signature
Credentials: _____

Patient / Policy Holder Signature
Date: _____

**Insurance Reimbursement Notice to Member:** This document is a statement of services rendered and fees collected. It contains standard industry coding (CPT procedure codes and ICD-10 diagnosis codes) required by insurance carriers for the processing of chiropractic claims. This invoice serves as a formal claim document for direct patient reimbursement, subject to the terms, limitations, and deductibles of your specific health insurance policy coverage.