MEDICAL SERVICES INVOICE

Provider Name:

Clinic/Facility:

Address:

Phone:

Email:

NPI:

Tax ID:

INVOICE

Invoice Number:

Invoice Date:

Payment Due Date:

PATIENT INFORMATION

Patient Name:

Date of Birth:

Address:

Phone:

INSURANCE INFORMATION

Insurance Carrier:

Policy Number:

Group Number:

Authorization Code:

Date of Service	CPT/HCPCS	ICD-10	Description of Service	Unit Cost ($)	Total ($)

Date of Service	CPT/HCPCS	ICD-10	Description of Service	Unit Cost ($)	Total ($)

PAYMENT TERMS & PROFESSIONAL NOTES

Total Charges:

Insurance Paid:

Copay/Co-insurance:

Total Due (Patient):

Authorized Professional Signature

Date