Provider Name
Address Line 1
Address Line 2
Phone: (000) 000-0000
Email: provider@email.com

Medical Billing Invoice

Billed To:

Patient Name
Address Line 1
Address Line 2
Phone: (000) 000-0000

Invoice Details:

Invoice #: _____
Date: _____
Patient ID: _____
Due Date: _____

Description of Service	Date	CPT Code	Quantity	Unit Price	Amount
Consultation	____/____/____	99213	1	_____	_____
Lab Test	____/____/____	80050	1	_____	_____

Notes / Terms:

Please make payment by the due date. Contact us if you have any questions regarding this invoice (insurance, payment plans, etc.).

Subtotal
_____
Insurance Adjustment
_____
Amount Due
_____