

# Specialist Medical Invoice Form

## Specialist Details

Name

Provider Number

Specialty

Clinic Address

Phone

Email

## Patient Details

Name

Date of Birth

Medicare Number

Address

Phone

## Invoice Details

Invoice Date

Invoice Number

Referring Doctor (if applicable)

## Services Provided

Date	Service Description	MBS/Item Code	Fee
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Total Fee

## Payment Details

Account Name

BSB

Account Number

Payment Notes

Additional Notes