

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