

# Medical Billing Invoice

Invoice #

## Date of Service

## Invoice Date

Provider Name

### Provider Address

Provider Phone

NPI #

Patient Name \_\_\_\_\_

Patient DOB

Patient ID / Insurance #

### Services Rendered

Date	Procedure/Service	CPT/Code	Diagnosis Code	Units	Fee	Total

Subtotal

Other Charges

Amount Paid

**Balance Due**

Comments / Notes

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Provider Signature

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Date