Medical Invoice Form

Date: _____ **Invoice #:** _____

Provider Information

Provider/Clinic Name: _____
Address: _____
Phone: _____
NPI: _____

Patient Information

Patient Name: _____
Date of Birth: _____
Patient ID: _____
Insurance (if applicable): _____

Itemized Charges

Date of Service	Description of Service	CPT/HCPCS Code	Units	Charge ($)
			Total	

Notes / Additional Information

Provider Signature: _____ **Date:** _____