Medical Invoice Form

Provider Name: _____
Provider NPI: _____
Facility Name: _____
Date of Service: ____ / ____ / _____

Patient Name	_____		
Patient DOB	____ / ____ / _____	**Patient ID**	_____
Insurance Provider	_____		

Itemized Services

Date	CPT Code	Description	Units	Charge ($)
06/14/2024	99213	Office Visit, Est. Patient, 15 min	1	85.00
06/14/2024	87070	Bacterial Culture, Other Source	1	45.00
06/14/2024	81001	Urinalysis, Automated, With Microscopy	1	25.00
06/14/2024	93000	Electrocardiogram, Routine ECG With Interpretation & Report	1	60.00
			TOTAL	**$215.00**

Notes / Additional Information

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This detailed medical invoice includes CPT codes for accurate billing and streamlined insurance processing. Please contact our office with any questions.