Medical Invoice Form

Invoice Date: _____

Invoice Number: _____

Patient Information

Name:	_____	**Date of Birth:**	_____
Patient ID/Chart #:	_____	**Phone:**	_____
Address:	_____		

Provider Information

Provider Name:	_____	**Provider ID/NPI:**	_____
Facility/Practice Name:	_____	**Phone:**	_____
Address:	_____		

Treatment Details

Date of Service	Procedure/Service	CPT/ICD Code	Fee
_____	_____	_____	$_____
_____	_____	_____	$_____
		Total	**$_____**

Payment Details

Payment Due By:	_____	**Payment Method:**	_____
Insurance Provider:	_____	**Policy Number:**	_____
Amount Paid:	$_____	**Balance Due:**	$_____

Please contact our office with any questions regarding this invoice.