

INVOICE

Medical invoice template
avoinvoice.com

FROM

Your business name _____

Address _____

Phone · email _____

BILL TO

Client name _____

Client address _____

Phone · email _____

INVOICE #	DATE	DUE DATE
PROVIDER NPI / TAX ID	PATIENT DOB / ACCOUNT #	DIAGNOSIS CODE (ICD-10)
PLACE OF SERVICE		

DESCRIPTION	QTY × RATE	AMOUNT
Service: date, CPT code, description, fee		
Procedure / lab / vaccine: date, CPT code, fee		
Supplies / medication		
Self-pay or prompt-pay discount (negative)		
Payment received at visit (negative)		
Balance from prior statement		

NOTES & PAYMENT TERMS
Payment is due at the time of service unless other arrangements were made; balances are due within 30 days of the statement date. This statement contains the information needed for out-of-network reimbursement when the diagnosis code field is completed; submit it to your insurer with their claim form. Questions about charges: call the office within 30 days.

Subtotal

Tax

TOTAL DUE