Physician / Office Name

Your address line 1
Your address line 2
City, State, ZIP

1(123) 456-7899
info@youremail.com
www.yourwebsite.com

Bill To	Invoice #	Payment
Patient Name	e.g., 00000	e.g., Net 14
Address line 1		
Address line 2	Issue Date	Due Date
City, State, ZIP	1/1/2025	1/14/2025

Service date	CPT	Description	QTY	Amount
2/1/1925	99285	Emergency Room Visit (High Severity)	1	$600
2/2/1925	96374	IV Push, Initial Medication	1	$250
2/3/1925	80053	Comprehensive Metabolic Panel (CMP)	1	$1,000
2/4/1925	85025	Complete Blood Count (CBC) with Differential	1	$85
2/5/1925	71046	Chest X-ray (Two Views)	1	$75
2/6/1925	93000	Electrocardiogram (ECG) with Interpretation	1	$50
2/7/1925	96375	IV Push, Additional Medication	2	$1,300
2/8/1925	36410	Blood Draw (Venipuncture)	1	$40
2/9/1925	20552	Trigger Point Injection (1 or 2 Muscles)	3	$180
Total Estimated Cost:				**$3,580**

Payment Method(s):	e.g., Credit Card, check, online
Payment Link(s):	e.g., https://payhealthbill.com/
Notes:	