Physician / Office Name

Your address line 1 1(123) 456-7899

Your address line 2 info@youremail.com

City, State, ZIP 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
3/24/2022	13505	CHEST 2 VIEWS	1	$793.00
3/24/2022	90471	SCREEN PANEL,	2	$108.00
3/24/2022	94761	HB COMPREHENSIVE METABOLIC PANEL	2	$368.00
3/24/2022	90744	HB VITAMIN D 25-HYDROXY	1	$229.00
3/24/2022	85015	HB CORTISOL	3	$255.00
3/24/2022	82962	HB FERRITIN	1	$173.00
3/24/2022	92551	HB IRON LEVEL	1	$95.00
3/24/2022	92550	HB TRANSFERRIN LEVEL	1	$72.00
3/24/2022	85035	HB REF CELIAC SCREEN PANEL, GLIADIN IGA IMMUNOASSAY	3	$122.00
3/24/2022	48715	HB REF CELIAC SCREEN PANEL, TTG-IGA IMMUNOASSAY (Q)	1	$225.00
3/24/2022	21658	HB CBC WITH DIFFERENTIAL	4	$144.00
3/24/2022	13505	HB-XRAY EXAM CHEST 2 VIEWS	1	$793.00
3/24/2022	85476			

Payment Method(s): e.g., Credit Card, check, online

Payment Link(s): e.g., https://payhealthbill.com/

Notes: