Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

# INVOICE

**Invoice #:** _____

**Date of Service:** _____

**To:**

Name: _____

Address: _____

_____

**For:**

Patient Name: _____

MRN: _____

| **EXAM TYPE AND MEDICAL RECORD DESCRIPTION** | **Charged Amount** | **Total Contrast** | **AMOUNT** |
|---|---|---|---|
| MRI_____, CPT_____ | | | $ |
| Gadovist, HCPC A9585 | | $2.50/unit | $ |
| | | TOTAL: | |

Document Scanned by: (cwid) _____

Make all checks payable to Weill Cornell Imaging at NewYork-Presbyterian

**Thank you for your business!**

Reviewed: February 2025