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 |
|---|---|---|---|
| PET_____, CPT_____ | | | $ |
| FDG, HCPC A9552 | | $1,757.00/unit | $ 1,757.00 |
| | | TOTAL: | |

Document Scanned by: (cwid) _____

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

**Thank you for your business!**

Reviewed: February 2025