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**
Xray_____, CPT_____			$ $
		TOTAL:	

Document Scanned by: (cwid) _____

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

Thank you for your business!

Reviewed: February 2025