# Medical Billing Invoice

*This invoice is issued for services rendered to the patient listed below. It is intended for the patient or the patient’s insurance provider for reimbursement or payment purposes.*

## Provider Information

**Provider Name:** {providerName}
**Clinic/Hospital:** {clinicName}
**Address:** {providerAddress}
**Phone:** {providerPhone}
**Email:** {providerEmail}

## Patient Information

**Patient Name:** {patientName}
**Patient ID:** {patientId}
**Date of Birth:** {patientDob}
**Insurance Provider:** {insuranceProvider}
**Insurance Policy Number:** {insurancePolicyNumber}

{#hasInsurance}

Insurance Billing Notice: This invoice will be submitted to the patient’s insurance provider for coverage consideration.

{/hasInsurance}

{^hasInsurance}

Direct Billing Notice: This invoice is to be paid directly by the patient as there is no insurance coverage provided.

{/hasInsurance}

## Services Rendered

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Service Code** | **Description** | **Quantity** | **Unit Price** | **Total** |
| {#services}{date} | {code} | {description} | {quantity} | {unitPrice} | {total}{/services} |

### Total Summary

**Subtotal:** {subtotal}
**Tax:** {tax}
Total Amount Due: {totalDue}

## Payment Instructions

 Please make the payment by **{dueDate}** using the following method(s). Ensure that the invoice number (**{invoiceNumber}**) is referenced in your payment.

Accepted Payment Methods:

{#paymentMethods}

* {method}

{/paymentMethods}

## Contact and Support

 For any billing inquiries, please contact **{billingContactName}** at **{billingContactPhone}** or **{billingContactEmail}**.

*Thank you for choosing {clinicName}.*