## Invoice Template for billing Organistaions

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| --- |
| **ATT**:  Address Line 1  Address Line 2  Address Line 3  POSTCODE  **Invoice Date**:  **Invoice No:** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CONSULTANT INFORMATION** | | | | | | | | | | | | | | | | | | |
| **Title:** |  | | **Surname:** | | | | |  | | | | **First name(s):** | | | | |  | |
| **Provider / professional no:** | | | | | If you are recognised by the insurer, you will be issued with a provider number. Otherwise enter your professional number (GMC/HPC) | | | | | **Specialty:** |  | | | | | | | |
| **Telephone no:** | |  | | | | | | | | **Email:** |  | | | | | | | |
| **Billing address:** | | | | | | | | | | **Payment Details:** | | | | | | | | |
|  | | | | | | | | | | **BACS Transfer:**  **Account no: Sort code:** | | | | | | | | |
| **Cheque:** | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | |
| Title: |  | | Surname: | | | |  | | | | First name(s): | | |  | | | | |
| Paying Organisation: | | |  | | | | | | | | Policy no: (if applicable) | | | | | This is the number issued to the patient by the insurer. | | |
| Patient Address: | | | | | | | | | | | D.O.B: | |  | | | | | |
|  | | | | | | | | | | | Authorisation no: (if available) | | | | | | | |
| The pre-authorisation code obtained by you or the patient from the insurer | | | | | | | |
| If you are not the lead consultant, please provide the name of the consultant in charge of overall patient care. | | | | | | | | | | | | | | | | | | |
| Name of lead consultant: | | | |  | | | | | | Provider / professional no: | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | |
| TREATMENT DETAILS | | | | | | | | | | | | | | | | | | |
| Location of treatment: | | | | | | | | | Should indicate when treatment was carried out. The admission and discharge dates are required for inpatient care | | | | | | | | | |
| Diagnosis code / description: (if applicable) | | | | | | | | |  | | | | | | | | | |
| TREATMENT CHARGES & FEES | | | | | | | | | | | | | | | | | | |
| Please include code and description of procedure where the treatment was procedural. | | | | | | | | | | | | | | | | | | |
| DATE OF TREATMENT | | | | | | DESCRIPTION / PROCEDURES | | | | | | TREATMENT SETTING | | | | | | FEE |
|  | | | | | | Description of the service carried out and procedure information if the treatment was procedural. Procedure codes can be found on the CCSD website or the respective insurer website. | | | | | | Whether the care is delivered as an inpatient, outpatient, day case, or consulting room. | | | | | |  |
|  | | | | | |  | | | | | |  | | | | | |  |
| TOTAL AMOUNT: | | | | | | | | | | | | | | | | | | £0.00 |