

Name of Clinician

Practice Name

Address

Phone Number

Texas Blue Chip INVOICE

INVOICE #:

Date:

**BILL TO: Blue Chip Program**

|  |  |
| --- | --- |
| **DESCRIPTION** |  **Detail/ Unit/Amount** |
| Client Identifier **DO NOT** include a name, badge number, department, social security number, or birthdate. Use a non-descript identifier only  |  |
| Service description  |  |
| Unit Price |  |
| Number of Units |  |
| **TOTAL AMOUNT:** |  |

Invoice Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Terms: Due Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Customer ID: