A close up of a chip

Description automatically generated

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: