|  |  |  |
| --- | --- | --- |
| **HOSPITAL NAME** | | |
| Street Address | Phone: | (413) 555-0190 |
| Address2 | Fax: | (413) 555-0191 |
| City, ST Zip Code | E-mail: | someone@example.com |

**SERVICE CHARGES  
Invoice#** 09-987 **Bill To:** Name

**Date:**  May 5, 2016 **Company Name:**

**Customer ID:** 098 **Street Addresses**

**Bed Number**: Bed Number **Address2**

**Admission Date** [Date] **Discharge Date** [Date] **City, ST, Zip code**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sr# | Medicine | Equipment | Amount | Payment | Balance |
| 1 | Panadol |  | $ 135.00 | 0 | $135.00 |
| 2 | Ceradip |  | $ 23.00 | 0 | $23.00 |
| 3 |  | Equipment | $250.00 |  | $250.00 |

**Signature HOSPITAL LOGO  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**