**<Name of Hospital/Clinic/Homecare/Nursing Home>
<Business Address> <Business Slogan, if any>
<Business Contact No.>
<Website/URL> INVOICE**

**LOGO**

|  |  |  |
| --- | --- | --- |
| **Patient Name****Address****Contact No.****Gender****Age** |  |  **Date:** **Number:** **Due Date:** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SR#** | **DESCRIPTION** | **MU** | **QTY** | **PRICE** | **AMOUNT** |
|  |  |  |  |  | **-** |
|  |  |  |  |  | **-** |
|  |  |  |  |  | **-** |
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|  |  |  |  |  | **-** |
|  |  |  |  |  | **-** |
| **Terms and conditions:** |  | **Sub-total****Tax Rate** **Tax** **Discount/s****Insurance Claim****Total Amount Due** | **-****-****-****-****-****-** |

|  |
| --- |
| **<State total amount due in words>** |

 **Signature
 \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 <Prepared by>
 <Designation>**