**Hospital name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date issued (yyyy-mm-dd): \_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎Outpatient 🞎Inpatient 🞎Second opinion  
Hospital ID No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | First\subsequent visit fee | Admission charges, etc. | Diagnostic procedure combination (DPC) | Medical supervision charges, etc | Home medical care |
| Insurance points |  |  |  |  |  |
| Patient liability |  |  |  |  |  |
|  | **Examinations** | **Diagnostic imaging** | **Medication** | **Injections** | **Rehabilitation** |
| Insurance points |  |  |  |  |  |
| Patient liability |  |  |  |  |  |
|  | **Specialised psychiatric treatment** | **Medical treatment** | **Surgery** | **Blood transfusion** | **Anesthesia** |
| Insurance points |  |  |  |  |  |
| Patient liability |  |  |  |  |  |
|  | **Radiotherapy** | **Pathological diagnosis** | **Dental crown/restoration** | **Prescriptions** | **Subtotal** |
| Insurance points |  |  |  |  |  |
| Patient liability |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Dietary therapy | Documentation | Delivery charges | Extra room charges | Special or specified medical care |
| Patient liability |  |  |  |  |  |
|  | **Others** |  | | | **Subtotal** |
| Patient liability |  |  |  |  |  |
| Comments: | | | **Subtotal Tax** | | **Total Billed** |

**Thank You For Your Business!!!!**