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| [**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: Enter Customer ID Street Address

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 |