**Name of Hospital/Clinic/Homecare/Nursing Home
Address:
Business Contact No.:
URL:
 INVOICE**

**LOGO**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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** | **-****-****-****-****-****-** |

|  |
| --- |
| **Total Amounts in Words** |

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 <Prepared by>
 <Designation> <Business Slogan, if any>**