**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>**