MEDICAL BILL RECEIPT

Receipt Number : _____
Date : _____

Name of Medical Institution: _____
Practitioner Name: _____
License Number: _____
Address: _____
City/State/ZIP: _____

Patient Information:
Name: _____
Street Address: _____
City/State/ZIP: _____

Code	Description of Service/Medicine/Products	Qty	Rate	Line Total ($)

Subtotal: $_____
Tax Rate (_____): _____
Total: $_____
Amount paid: $_____

payment Method: _____
Card/Check No: _____