

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 Services/Medicine/Products | Qty | Rate | Line Total (\$) |
|------|---|-----|------|-----------------|
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Subtotal: \$ _____

Tax Rate (____): _____

Total: \$ _____

Amount Paid: \$ _____

Payment Method: _____

Card/Check No.: _____

