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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **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.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_