**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.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_