

# 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 (\$)

Subtotal: \$ \_\_\_\_\_  
Tax Rate (\_\_\_\_): \_\_\_\_\_  
Total: \$ \_\_\_\_\_  
**Amount Paid:** \$ \_\_\_\_\_

Payment Method: \_\_\_\_\_  
Card/Check No.: \_\_\_\_\_

