NAME OF HOSPITAL

Bill of Supply

Mobile No. : [redacted]

Patient Name : [redacted]

Age/Sex : [redacted]

Address : [redacted]

Referred By : [redacted]

Bill Date : [redacted]

MaxId / SSN : [redacted]

Bill No / Receipt No : [redacted]

GSTN Bill : [redacted]

GSTN No : [redacted]

Sl. No.	Services	SAC	Qty	Base Price(Rs.)	Tariff Price(Rs.)	Discounts	Net Amount (Rs.)	Tax Amt (Tax %)	Bill Amount (Rs.)
1	[redacted] (Consultation) (SHBG-GASTROENTEROLOGY)	[redacted]	1	800.00	800.00	0.00	800.00		800.00
			Total :			0.00	800.00	0.00	800.00

Paid by Patient : 800.00

Amount in Words : Rupees eight hundred only collected from patient

Sum Of Rs. 800.00 received with thanks from PATIENT NAME

Payment Mode(s)

Online Payment for Rs.800.0 TRANSACTION ID [redacted]

Signature of Patient/Next of Kin

Signature

ONLINE PAYMENT USER SIGNATURE

(This is system generated document and does not require signature)

Place of Supply : PLACE NAME

Company Name : HOSPITAL NAME

PAN No. : PAN NO.