HOSPITAL NAME __wfrvr_____
STREET ADDRESS ___dfv_____
CITY, STATE & ZIP ___eebec_____
TELEPHONE _____frwfre_____
FAX _____fer_____

Hosptial Logo

INVOICE NO. 12345902 DATE __10/05/1970___

BILL TO	SHIP TO (NAME)	ADDRESS
fhjjnh	thuyt	fghjk

S. NO.	MEDICINE	DESCRIPTION	AMOUNT	TOTAL

TOTAL

Signature

GENERIC INVOICE – MEDICAL AND HEALTH CARE

INVOICE NUMBER 9876540	INVOICE DATE* (YYYY-MM-DD) 11/08/1970	CONTACT ID	AUTHORIZATION NUMBER

PAYMENT INFORMATION

Payee name	Payee number*	GST registration number	
Mailing address for payment	City	Province	Postal code*
Telephone number (please include area code)	Fax number (please include are code)		

SERVICE RECIPIENT INFORMATION (WORKER OR OTHER PERSON WHO RECEIVED SERVICE)

Service recipient last name*	Service recipient first name*
Service recipient date of birth (yyyy-mm-dd)	Service recipient personal health number (care card number)
WorkSafeBC claim number*	Date of injury* (yyyy-mm-dd)

SERVICE INFORMATION

DATE OF SERVICE (YYYY-MM-DD)	FEE CODE *	DESCRIPTION	NUMBER OF ITEMS* (NUMBER OF UNITS)	COST PER UNIT *	LINE ITEM AMOUNT * (NOT INCLUDED TAXES)	PST (IF CHANGED)	GST (IF CHANGED)	LINE ITEM TOTAL* (INCLUDING TAXES)

TOTAL:

Thank You For Your Business!!

ABC Health care

A: 792, Cross st, TN
P: 044-98876-99877

Bill To:

DATE:
INVOICE NUMBER: 0987651

PATIENT:

Medicines/Descriptions	Charges	Quantity	TOTAL
		Sub-Total	
		Tax Vat (15%)	
CARD PAYMENT **We accept:** Visa, MasterCard We Accept: Cheque		**Discount (5%)**	
Terms & Conditions		**Grand Total**	[redacted]
Thank you for your business!			

HOSPITAL NAME		
Street Address	Phone:	(413) 555-0190
Address2	Fax:	(413) 555-0191
City, ST Zip Code	E-mail:	someone@example.com

SERVICE CHARGES

Invoice Number 09-987

Date: May 5, 2016

Customer ID: 098

Bed Number: Bed Number

Admission Date [Date]

Discharge Date [Date]

Bill To: Name

Company Name:

Street Addresses

Address2

City, ST, Zip code

Sr#	Medicine	Equipment	Amount	Payment	Balance
1	Panadol		$ 135.00	0	$135.00
2	Ceradip		$ 23.00	0	$23.00
3		Equipment	$250.00		$250.00

Signature

HOSPITAL LOGO

THANK YOU FOR YOUR BUSINESS!!!

HOSPITAL NAME and LOGO

INVOICE

INVOICE NUMBER: 4646454 **BILL TO:** **BILL FROM:**

INVOICE DUE: 20 AUGUST 2017

Prepared by:

No.	Items Description	Unit Price	Quantity	Total
1	Uyyuu	980	1	980
2	Tyyuuu	789	1	789
3	Yhhhhh	766	1	766
4	Uukkjjh	865	2	865
5	Uhgggg	890	1	890
6	Uffffffff	765	1	765
7	yuiookj	544	1	544
		GRAND TOTAL		**$13,000**

Payment Method:

Bank: Acc. No. **Regards:**

PayPal: payment@website.com

Card Payment We Accept: Visa, MasterCard

GENERIC INVOICE – MEDICAL AND HEALTH CARE

Invoice number 1234656	Invoice date* (yyyy-mm-dd)	Contact ID	Authorization number

Payment information

Payee name	Payee number*	GST registration number	
Mailing address for payment	City	Province	Postal code*
Telephone number (please include area code)	Fax number (please include are code)		

Service recipient information (worker or other person who received service)

Service recipient last name*	Service recipient first name*
Service recipient date of birth (yyyy-mm-dd)	Service recipient personal health number (care card number)
WorkSafeBC claim number*	Date of injury* (yyyy-mm-dd)

Service information

Date of service (yyyy-mm-dd)	**Fee code***	**Description**	**Number of items* (number of units)**	**Cost per unit***	**Line item amount* (not included taxes)**	**PST (if changed)**	**GST (if changed)**	**Line item total* (including taxes)**

INVOICE: _____

DOCTOR/MEDICAL PRACTICE _____
Street Address _____
Address 2 _____
City, State _____
Zip Code _____
Telephone _____
Fax _____

PATIENT'S NAME _____
Street Address _____
Address 2 _____
City, State _____
Zip Code _____
Telephone _____

PATIENT	INVOICE NUMBER	GENDER	WEIGHT	HEIGHT	DATE
	983567				

MEDICATION	MEDICAL SERVICES PERFORMED	RATE	TOTAL

Make all checks payable to _____

THANK YOU FOR YOUR BUSINESS!

Medical Expense Invoice

Hospital name: _____Date issued (yyyy-mm-dd): ___/_____/_____

Department: _____☐Outpatient☐Inpatient ☐Second opinion
Insurance type: (Percentage of patient liability: %) Billing
Period From__/_/___to__/__/___Payment due date (yyyy-mm-dd): Please pay the cashier's desk by _____/___/_____
Hospital ID No.:_____ Patient name: _____

	Invoice Number	Admission charges, etc.	Diagnostic procedure combination (DPC)	Medical supervision charges, etc	Home medical care
Insurance points	908643				
Patient liability					
	Examinations	Diagnostic imaging	Medication	Injections	Rehabilitation
Insurance points					
Patient liability					
	Specialized psychiatric treatment	Medical treatment	Surgery	Blood transfusion	Anesthesia
Insurance points					
Patient liability					
	Radiotherapy	Pathological diagnosis	Dental crown/restoration	Prescriptions	Subtotal
Insurance points					
Patient liability					

	Dietary therapy	Documentation	Delivery charges	Extra room charges	Special or specified medical care
Patient liability					
	Others				Subtotal
Patient liability					
Comments:			Subtotal	Tax	Total Billed

MEDICAL INVOICE

WCB Claim Number								
Invoice Number								
1	2	4	3	5	6	7	8	9

Worker's Last Name	First Name	Initial	Date of Birth ___/___/____
Mailing Address:	City/Town:		Post code:
Telephone Number	Gender: □ Male □ Female		Date of Accident: ____/____/____
Part of Body	Side of Body	Nature of injury	
Name of Referring Physician			

Date of Service	Health Service Code	Diagnostic Code	Modifier	Skill Code	Calls	Encounter	Fees submitted
							$
							$
							$
							$
							$
					Total Amount Billed:		$

Dialing Number	Contact ID	Facility Type
Name and Address to whom fees payable	Signature	Printed Name
	Telephone Number	Fax number
	Providers reference number	Date

Cayuga Medical Center at Ithaca

Phone no: 354 56577

Office hours: 8.00 a.m. to 9.00p.m

1. Patient Name	
Kevin E.	
2. Service Date From/Through	3. Statement Date
06-06-2003 to 06-06-2003	06-06-2003

Kevin E.,

345, ddd road,

ITHACA, NY-14080

Invoice Number	Previous Balance	Charges	Payments/Adjs	Amount Due from Patient
4546757576	0.00	595.00	48.7	643.67

Account number	Patient name	Service Date(s)	Statement Date(s)	Page
4546757576	0.00	06-06-2003 to 06-06-2003	06-06-2003	1

Dates	Descriptions	Charges	Est has Coverage	Payments/Adjs
		TOTAL		
			Amount Due from Patient	

Thank you for your business!

Signature

HAPPYLIFE

WWW.HAPPYLIFE.COM

2ND INVOICE

May 31, 2016

YOUR PHYSICIAN
5767, MAIN STREET
ANYWHERE, USA 4566

Customer Name: JONE BLACK
Customer ID: 676768787

PHYSICIAN BILLING STATEMENT

Invoice number	Date	Amount	Paid
889-98989-8899	May 31, 2017	$25.98777	677878

Past History

JANUARY 2014	FEBRUARY 2014	MARCH 2014	APRIL 2014	MEDICAL
655767.889	676788.999	768787.000	789789.00	

Complete Detail

CURRENT CHARGES	PHYSICAL CHECK THERAPY LASSER TREATMENT ANERGY CHECK	6767.09 768 7676 765	
PREVIOUS BILL			569
TOTAL:		51335456	

PAID AMOUNT	51335456

Signature

Bill To: Name
Company name
Street address, Place holder

[HOSPITAL NAME]		
Street Address	Invoice Number:	AK 555-0190
Address2	Fax:	(413) 555-0191
City, ST Zip Code	E-mail:	someone@example.com

SERVICE CHARGES

Intial# 09-987

Bill To: Name

Date: May 5, 2016

Company Name

Customer ID: Enter Customer ID

Street Address

Bed Number: Bed Number

Address2

Admission Date:[Date] Discharge Date [Date]

City, ST, Zip code

Sr #	Medicine	Equipment	Amount	Payment	Balance
1	Panadol		$ 135.00	0	$135.00
2	Ceradip		$ 23.00	0	$23.00
3		Equipment	$250.00		$250.00