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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Ambulance Bill** | | | | | | | |
| **Company Name:**  Address:    City, State, Country:  ZIP Code:  Phone No.:  Email ID: | | | | | | | |
|  | | | | | | | |
| **Patient Details:** | | | | | **Invoice No.:** |  | |
| Name: | | | | | **Date:** |  | |
| Address: | | | | |  | | |
|  | | | | |  | | |
| City, State, Country: | | | | |  | | |
| ZIP Code: | | | | |  | | |
| Contact No.: | | | | |  | | |
| **#** | **Service name** | **HSN** | **QTY** | **Unit** | **Price/ Unit** | **Disc** | **Amount** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| **Total** | | |  |  |  |  |  |
|  | | | | | | | |
|  | | | |  | **Sub Total:** | |  |
| Discount: | |  |
| **Amount in words:** | | | | Tax Rate: | |  |
| Tax Value: | |  |
| **Total** | |  |
| Received | |  |
|  | | | | Balance | |  |
| **Company seal and Sign** | | | |  | | |
|  | | |
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