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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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