Bill Number :

Customer Name :

Phone No :

|  |  |
| --- | --- |
| **Medical Bill** | |
| Name Of The shop :  Address :    Phone No : Email Id : |  |
| Billing To | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| S.No | Item Name | Qty | MRP | Amount |
|  |  |  |  |  |
| Amount in Words | | Total : | |  |
| GST : | |  |
| Grand Total : | |  |

Notes:

Authorized Signature

