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

