|  |  |
| --- | --- |
|  MEDICAL INVOICE |  |
| Company Name: |  |
| Bill from: | Customer Details | Bill details |
| CIN Number: | Name: | Bill No.: |
| Address: | Address: | Booking ID: |
|   |   | Sample Collection: |
| Phone No.: | Contact Number: | SAC code: |
| GSTIN: |   |   |
| Test Description | Quantity | Price /Unit | GST (%) | Amount |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|   | **Sub Total** |  |
| **Amount In Words:** | Discount: |   |
| **Final Amount:** |  |
| Amount Paid: |   |
| Balance: |  |
|   |
| **Declaration:** |
|   |
| Client's Signature | Business Signature |
|
|  |

