DISCHARGE INVOICE

Invoice No: _____

Date: _____

Admission Date: _____

Discharge Date: _____

PATIENT INFORMATION

Patient Name:
Patient ID:
Date of Birth:
Gender:
Contact Number:
Attending Physician:
Insurance Provider:
Policy Number:

ITEMIZED MEDICAL CHARGES

Date	Code	Description of Service / Treatment	Qty	Unit Price	Total

Total Gross Charges: _____

Insurance Covered: _____

Co-Pay / Deductible: _____

Adjustments / Discounts: _____

Balance Due: _____

Patient / Guarantor Signature

Authorized Billing Representative