DISCHARGE RECEIPT

Receipt No:

Date:

PATIENT INFORMATION

Patient Name:

Patient ID:

Age / Gender:

Contact No:

Admission Date:

Discharge Date:

Ward / Bed No:

Attending Doctor:

DISCHARGE DIAGNOSIS SUMMARY

Primary Diagnosis:

Discharge Status:

MEDICAL BILLING & FEES

S.NO.	DESCRIPTION OF SERVICES / CONSUMABLES	QTY	UNIT PRICE	TOTAL AMOUNT

Subtotal:

Tax / Surcharge:

Insurance Covered:

Discount / Adjustments:

Net Amount Due:

Prepared By (Billing Dept)

Authorized Signatory

Patient / Guardian Signature