

# HOSPITAL INVOICE

## DETAILS

DATE: \_\_\_\_\_

INVOICE NO. \_\_\_\_\_

## FROM

COMPANY: \_\_\_\_\_

ATTN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

## BILL TO

COMPANY: \_\_\_\_\_

ATTN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

DESCRIPTION		AMOUNT (\$)
<p>NOTES: _____</p> <p>_____</p> <p>_____</p>		SUBTOTAL
		DISCOUNT
		TAX / VAT
		TOTAL

THANK YOU FOR YOUR BUSINESS

