

## SYNERGY MULTISPECIALTY HOSPITAL LLP

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## **Bill Receipt**

Bill Date: Not Mention

Patient Name: Not Mention

Age:

Patient Company:Not Mention

**Consulting Doctor:**Not Mention

Bill Time:Not Mention

**UHID:**Not Mention

Sex:Not Mention

Sr.No.	Service Code	Service Name	Qnty.	Rate	Amount					
1	1333	Blood Test	1	100	100					
2	1333	Blood Test	1	100	100					
3	1333	Blood Test	1	100	100					
				Total Amount(RS.)	100.00					
				Net Amount(RS.)	100.00					
Payment Details										
Sr. No.	Mode Of Payment Not Mention	<b>Trans No</b> Not Mention	Date	Bank Detail	Amount Not Mention					

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