

## 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 N	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
		Paymen	t Details		
Sr. No.	Mode Of Payment Not Mention	Trans No Not Mention	Date	Bank Detail	<b>Amount</b> Not Mention