

Discharge Bill**HOSPITAL****Bill No :****Date :****Time :**

Reg.No. :

Contact :

Address :

Patient Name :

C/O :

Age :

Gender :

Consultant :

Date Of Admission :

Ward :

Bed No :

Date Of Discharge :

S.No.	Particular / Services	(Active) Date / Time	(Inactive) Date / Time	Unit	Days / Qty	Rate	Amount

Total Paid Amount :**Sub Total :****Total Dues Amount :****G.S.T :****Received Amount :****Discount :****Balance Amount :****Round Off :****Amount (In Words) :**

For,

Hospital

Authorised Signature