BILL / MONEY RECEIPT

Bill No.:
Name:
Address:
Contact:
Ref by.:

P.ID:
Age/Sex:

Date:
Rep.Del.: 7:30 PM to 8:30 PM
Associate:
Sub Associate:
Sample Src:

Parameter Name	Specimen	Dept	Test Date	Report Date	Rate

No of test(s):
Case His.:
Remarks:

Rs. In word:

Gross Amount:
Discount:
Coll. Charge:
Net Amount:
Rcvd Amount:
Due Amount:

E. & O. E