PHARMACY NAME

123 Medical Boulevard
City, State, Zip
Phone: (555) 000-0000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFO:

Name: _____
Address: _____
ID: _____

PRESCRIBER INFO:

Doctor: _____
License: _____
NPI: _____

Medication / Description	Qty	Unit Price	Total

Subtotal: $_____
Tax: $_____
Grand Total: $_____

Pharmacist Signature: _____

Notice: Please verify all medications before leaving the premises. Keep this receipt for your insurance records.