PHARMACY NAME

123 Health Ave, Medical City
Phone: (555) 000-0000
License: #00000000

INVOICE

Date: _____
Invoice #: _____

PATIENT INFO:

Name: _____
Address: _____
ID/DOB: _____

INSURANCE/PRESCRIBER:

Provider: _____
Prescriber: _____
NPI: _____

Rx Number	Description / Medication	Qty	Unit Price	Total

Subtotal: $_____
Insurance Copay/Discount: ($_____)
Tax: $_____
Amount Due: $_____

Pharmacist Signature: _____

Thank you for choosing our pharmacy. Please keep this for your medical records.