# PROFORMA INVOICE

[Hospital/Clinic Name]
[Address Line 1]
[Address Line 2]
Phone: [Phone Number]

**Date:** ___________

**Invoice #:** ___________

**Validity:** ___________

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**Bill To:**

[Patient/Payer Name]
[Patient ID / DOB]
[Address]
[Contact Number]

**Shipping Info (If Applicable):**

[Recipient Name]
[Hospital/Department]
[Surgery Date/Reference]

| Item Code/SKU | Description (Device/Implant Name) | Lot/Batch # | Qty | Unit Price | Total |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Subtotal: ________________
Tax/VAT: ________________
Shipping/Handling: ________________

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**GRAND TOTAL: ________________**

**Payment Terms & Instructions:**

Bank: [Bank Name] | Account: [Account Number] | SWIFT/IBAN: [Code]

Notes: [e.g., Lead time for custom prosthetics, sterilization requirements, or warranty info]

________________________
Authorized Signature

________________________
Patient/Representative Signature