

HOSPITAL NAME

123 Medical Plaza, Health City
Phone: (555) 000-0000

DISCHARGE INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name: _____

ID: _____

Address: _____

STAY DETAILS

Admission: _____

Discharge: _____

Attending: _____

Description of Services / Medication	Code	Qty/Days	Unit Cost	Total
Room & Board (Semi-Private/Private)				
Laboratory & Diagnostic Tests				
Pharmacy / Medications				
Surgical / Procedural Fees				
Nursing & Staff Support				
Miscellaneous Supplies				

Subtotal: \$ _____
Insurance Adjustments: (\$ _____)
Tax: \$ _____

Total Amount Due: \$ _____

Payment Terms: Due upon discharge or within 30 days of invoice date.

Please make all checks payable to [Hospital Name]. For billing inquiries, contact the Financial Services Department.