

LIFE SUPPORT EQUIPMENT INVOICE

Provider License No:

Invoice #:

Date:

SERVICE PROVIDER

Phone:

PATIENT / CLIENT INFORMATION

Address:

Patient ID:

Insurance Policy:

Model/Serial #	Equipment Description & Clinical Service	Qty	Unit Price/Rate	Total

Subtotal:

Tax/VAT:

Amount Due:

TERMS & CERTIFICATION

I certify that the electronic life support equipment listed above has been inspected, sanitized, and calibrated according to manufacturer specifications and medical safety standards.

Payment Terms:

Authorized Signature: _____

Date: _____