SUMMARY BILL FORMAT

Provider Name		Bill Number	
Provider Registration No.		Bill Date	
Address		PAN Number	
IP No.		Service Tax Regn. No.	
Patient Name		Date of Admission	
Payer Name	XXXX InsuranceCompany Ltd	Date of Discharge	
Member Address		Bed Number	

Billing Summary

Sl No	**Primary Code**	**Particulars**	**Amount**
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	
Amount paid by Member	
Amount charged to Payer	
Discount Amount	
Service Tax	
Amount Payable	
Amount in Words	Rupees XXX Only

Patient's Signature

Authorized Signatory