

BILL / MONEY RECEIPT

Bill No.:
 Name:
 Address:
 Contact:
 Ref by.:

P.ID:
 Age/Sex:

Date:
 Rep.Del.: 7:30 PM to 8:30 PM
 Associate:
 Sub Associate:
 Sample Src:

Parameter Name	Specimen	Dept	Test Date	Report Date	Rate
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No of test(s): Case His.: Remarks: Rs. In word:	Gross Amount: Discount: Coll. Charge: Net Amount: Rcvd Amount: Due Amount:
	E. & O. E