Maternity Hospital Bill Receipt

Maternity Hospital Name

Address

Contact Information

Website (if applicable)

Date of Issue: [DD/MM/YYYY]

Receipt No: [Unique Receipt Number]

Patient Information

Patient Name: [Full Name]

Patient ID: [Unique Patient ID]

Address: [Patient Address]

Phone Number: [Patient Contact Number]

Date of Admission: [DD/MM/YYYY]

Date of Delivery: [DD/MM/YYYY]

Doctor in Charge: [Doctor's Name]

Bill Details

Description	Quantity	Unit Price	Amount
Room Charges (Maternity Ward)	[X days]	[Amount/day]	[Total]

Obstetrician Fee	[Number of visits]	[Amount/visit]	[Total]
Delivery Charges (Normal/C-section)	[Delivery Type]	[Amount]	[Total]
Medical Tests	[Details]	[Amount/test]	[Total]
Medication Charges	[Details]	[Amount]	[Total]
Postnatal Care (Nursing)	[X days]	[Amount/day]	[Total]
Other Services (e.g., Newborn Screening)	[Details]	[Amount]	[Total]

Total Amount

Total Before Tax: [Amount]

Tax (if applicable): [Tax %]

Total Amount (Including Tax): [Final Amount]

Payment Details

Mode of Payment: [Cash/Credit Card/Insurance]

Amount Paid: [Paid Amount]

Amount Due: [Due Amount] (if any)

Authorized Signature:

[Signature of Hospital Official]

[Designation]