horizontal line**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]**