MEDICAL RECEIPT

For Insurance Reimbursement

Healthcare Provider Details

Provider/Clinic Name	Dr. Jane Doe Health Clinic
Address	123 Wellness Ave, Cityville, State, 123456
Contact Number	(123) 456-7890
Registration/Licence No.	MED123456

Patient Details

Name	John Smith
Patient ID	PAT123456
Date of Birth	01/01/1980
Contact Number	(987) 654-3210

Treatment Details

Diagnosis	Upper Respiratory Infection
Date of Consultation	2024-06-01
Treating Doctor	Dr. Jane Doe, MBBS, MD

Itemized Charges

Service/Item	Description	Amount (INR)
Consultation Fee	Medical Consultation	800.00
Medication	Antibiotics & Cough Syrup	600.00
Laboratory Test	Blood Test (CBC)	400.00
	Total	**1800.00**

Mode of Payment

Payment Method	Credit Card
Transaction Date	2024-06-01
Receipt Number	RCPT-20240601-001

Declaration

I hereby confirm that the above services were rendered and payment was received.

Doctor's Signature: _____
Stamp: _____

Note: Please attach this original receipt along with required forms for insurance reimbursement. Alterations or tampering will render this document invalid.