

## Medical Receipt

**Provider Name:** Green Valley Medical Clinic

**Provider Address:** 123 Wellness Ave, Healthy City, ST 12345

### Patient Information

Patient Name	Date of Birth	Patient ID
Jane Doe	1990-01-15	GV1234567

### Receipt Details

Date of Service	Description	CPT Code	Cost
2024-06-30	Office Consultation	99213	\$120.00
2024-06-30	Blood Test	80050	\$60.00

Payment Method	Date Paid	Amount Paid
Credit Card	2024-06-30	\$180.00

**Total Amount:** \$180.00

**Notes:** This receipt is issued for insurance reimbursement purposes and includes all relevant patient, treatment, and payment details necessary for claim processing.

*Signature:* \_\_\_\_\_

*Date:* 2024-06-30