患者氏名　：
患者 ID　　：

Medical Expense Invoice

Date issued (YYYY/MM/DD):_____/_____/_____

Hospital name:_____

☐**Outpatient** ☐**Inpatient** ☐**Second opinion**

Department：_____

Insurance type:_____ **(Percentage of patient liability:____%)**

Billing period: From_____/_____/_____to_____/_____/_____

Payment due date (YYYY/MM/DD): Please pay at the cashier's desk by_____/_____/_____.

Hospital ID No.:_____

Patient name:_____

	First/subsequent visit fees	Admission charges, etc.	Diagnostic procedure combination (DPC)	Medical supervision charges, etc.	Home medical care
Insurance points					
Patient liability	¥	¥	¥	¥	¥
	Examinations	**Diagnostic imaging**	**Medication**	**Injections**	**Rehabilitation**
Insurance points					
Patient liability	¥	¥	¥	¥	¥
	Specialized psychiatric treatment	**Medical treatment**	**Surgery**	**Blood transfusion**	**Anesthesia**
Insurance points					
Patient liability	¥	¥	¥	¥	¥
	Radiotherapy	**Pathological diagnosis**	**Dental crown restoration / Prosthodontics**	**Prescriptions**	**SUBTOTAL**
Insurance points					
Patient liability	¥	¥	¥	¥	¥

	Dietary therapy	Documentation	Delivery charges	Extra room charges	Special or specified medical care
Patient liability	¥	¥	¥	¥	¥
	Others				**SUBTOTAL**
Patient liability	¥				¥

Comments：

Sales tax		TOTAL BILLED
Subtotal to be taxed	Tax	
¥	¥	¥