

# Invoice

**From:**  
Surjabasha

**To:**  
7028439986

**Hospital Details:**

Hospital Name	Address
Chelaram	Akurdi

Type	Test Name	Price
Test	Blood Test	2100

**Invoice Date:**  
2024-07-18

Thanks for choosing Surjabasha for Booking| [surjabasha@gmail.com](mailto:surjabasha@gmail.com)

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