<Provider Logo> <Provider Address

The Christie NHS Foundation Trust
Proton Therapy Department
Wilmslow Rd
Manchester M20 4BX
Great Britain

INVOICE: No.
INVOICE DATE: Dt.

SAMPLE INVOICE ONLY

Itemised summary

		Check Out Date	Reference	Amount	Nights	Cancellations	Nightly Charge
Guest: nnnnnnnnn							
	n-bed	Date	Ref.	£xx.xx	y	-	£zz.zz
Total				**xx.xx**	**y**	**-**	**zz.zz**
Guest: nnnnnnnnn							
	n-bed	Date	Ref.	£xx.xx	y	-	£zz.zz
Total				**xx.xx**	**y**	**-**	**zz.zz**
Guest: nnnnnnnnn							
	n-bed	Date	Ref.	£xx.xx	y	-	£zz.zz
Total				**xx.xx**	**y**	**-**	**zz.zz**
Guest: nnnnnnnnn							
	n-bed	Date	Ref.	£xx.xx	y	-	£zz.zz
Total				**xx.xx**	**y**	**-**	**zz.zz**

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Monthly Balance

Ex. VAT		**xx,xxx.xx**
VAT	20%	**yy,yyy,yy**
VAT adjusted for long stay	4%	**z,zzz.zz**

Total Balance (incl VAT)	xx,xxx.xx

This invoice is due for payment within 30 days of invoice date. Please quote your account number and invoice number in all correspondance

Your Account Number : Ref.

Payment Details:

<Provider Bank Details>