

# REFUND INVOICE

Clinical Provider Name \_\_\_\_\_

Address / Contact \_\_\_\_\_

REFUND NUMBER  
DATE ISSUED

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## PATIENT INFORMATION

Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Phone: \_\_\_\_\_

## REFUND RECIPIENT (IF DIFFERENT)

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Relation: \_\_\_\_\_

Original Date of Service	Description of Service / Reason for Refund	Amount
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ORIGINAL PAID:

**TOTAL REFUND:**

## REFUND METHOD

Check    Credit Card    Insurance Adjustment    Other: \_\_\_\_\_

AUTHORIZED SIGNATURE

DATE APPROVED

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Confidential Medical Billing Document. For billing inquiries, please contact the accounting department.