REFUND INVOICE

[Medical Facility Name]

[Street Address]
[City, State, Zip]

PATIENT INFORMATION
[Patient Full Name]
[Patient ID/Account Number]
[Address Line 1]
[City, State, Zip]

REFUND DETAILS
Refund #: [000000]
Original Invoice #: [000000]
Date Issued: [MM/DD/YYYY]
Payment Method: [Original Payment Method]

Service Date	Description of Service	Reason for Refund	Amount
[MM/DD/YYYY]	[CPT Code / Service Description]	[Overpayment / Insurance Adjustment]	$0.00
[MM/DD/YYYY]	[CPT Code / Service Description]	[Duplicate Payment / Cancellation]	$0.00

Original Charged: $0.00
Insurance Paid: $0.00
TOTAL REFUND: $0.00

AUTHORIZED SIGNATURE

This is a formal notice of refund processing. Please allow 7-10 business days for the funds to reflect in your account.
For billing inquiries, contact [Department Phone Number] or [Email Address].