

REFUND INVOICE

[Healthcare Facility Name]

[Facility Address]

DATE ISSUED
REFUND ID

PATIENT INFORMATION

Name:

Account #:

Address:

PAYMENT REFERENCE

Original Service Date:

Original Receipt #:

Method of Refund:

Description of Service / Reason for Overpayment	Amount Paid	Actual Cost
	\$	\$

Gross Overpayment: \$ _____

Adjustments: \$ _____

TOTAL REFUND: \$ _____

NOTES / REMARKS

AUTHORIZED SIGNATURE
DATE SIGNED

Confidential Medical Billing Document | For inquiries, contact [Phone Number] or [Email Address]