

BILLING REFUND INVOICE

Refund # : _____

Date: _____

Provider Information

Name: _____

NPI/Tax ID: _____

Address: _____

Phone: _____

Patient Information

Name: _____

Patient ID: _____

Address: _____

DOB: _____

Date of Service	Description of Services	Original Amount Paid	Refund Amount

Total Refund Due: \$ _____

Reason for Refund

Overpayment Insurance Adjustment Duplicate Payment Other: _____

Method of Refund: Check # _____ Credit Card ACH/Direct Deposit

Authorized Signature: _____ **Date:** _____