

REFUND ADVICE

[Hospital Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Date: [MM/DD/YYYY]
Refund ID: [000000]
Patient ID: [000000]

PATIENT INFORMATION

[Patient Full Name]
[Street Address]
[City, State, Zip]

REFUND METHOD

Method: [Check / Credit Card / ACH]
Reference: [Transaction #]
Status: Pending Approval

ACCOUNT SUMMARY

Service Date	Description of Service	Original Charge	Credit Balance
[MM/DD/YYYY]	[Service Description / Account Overpayment]	\$0.00	\$0.00
[MM/DD/YYYY]	[Insurance Adjustment / Duplicate Payment]	\$0.00	\$0.00

Total Credit Balance: \$0.00

Processing Fee (if applicable): \$0.00

Total Refund Amount: \$0.00

REASON FOR REFUND

[Detail reason: e.g., Overpayment by patient, Insurance adjustment, Duplicate billing]

This is a formal notice of a credit balance refund. For billing inquiries, please contact the Patient Accounts Department.

Authorized Signature: _____ *Date:* _____