REFUND INVOICE

[Institution Name]

Invoice #:
Date:
Reference #:

Patient Information

Name:
ID:
Address:

Refund Method

Type: [ ] Check [ ] Credit Card [ ] Insurance
Payee:

Refund Details

Service Date	Description of Services	Original Charge	Adjustment Amount
		Total Refund Amount:	

Reason for Refund

[ ] Overpayment [ ] Insurance Adjustment [ ] Duplicate Billing [ ] Other: _________________

Authorized Signature
Billing Department

Date