REFUND INVOICE

[Medical Practice Name]

[Practice Address]

REFUND NUMBER
REFUND DATE

PATIENT INFORMATION

Name:

ID/Account #:

Address:

ORIGINAL BILLING REFERENCE

Original Invoice #:

Date of Service:

Payment Method:

Description of Service	Original Amount	Adjustments	Refund Amount

TOTAL CREDIT:
$

TOTAL REFUND:
$

REASON FOR REFUND

AUTHORIZED SIGNATURE
DATE PROCESSED

For billing inquiries, please contact our office at [Phone Number] or [Email].