BILLING REFUND INVOICE

[Practice Name]

[Provider NPI/Tax ID]

Date Issued
Refund Reference #

Patient Information
Name:

Patient ID:

Address:

Refund Recipient (if different)
Name:

Method: [ ] Check [ ] Card [ ] ACH

Reference ID:

Date of Service	Description / CPT Code	Original Paid	Refund Amount

Total Refund: $
Reason for Refund
[ ] Overpayment [ ] Insurance Re-adjudication [ ] Duplicate Charge [ ] Cancellation

Notes:

Authorized Signature
Date