

REFUND INVOICE

[Practice Name]
[Office Address]
[City, State, Zip]
[Phone Number]

REFUND ID: [000000]
DATE ISSUED: [MM/DD/YYYY]

PATIENT INFORMATION:

[Patient Full Name]
[Patient ID / Account #]
[Mailing Address]
[City, State, Zip]

REFUND METHOD:

[Check / Credit Card / Cash]
[Reference / Auth #]

Service Date	Description of Service	Original Amount Paid	Refund Amount
[MM/DD/YYYY]	[Reason: Overpayment / Insurance Adjustment / Duplicate Payment]	\$0.00	\$0.00

TOTAL REFUNDED: \$0.00

NOTES:

[Additional comments regarding the reimbursement]

AUTHORIZED SIGNATURE

If you have questions regarding this refund,
please contact our billing department.