REFUND INVOICE

[Practice Name]
[Address Line 1]
[City, State, Zip]

Refund Date: [MM/DD/YYYY]
Refund ID: #000000
Original Invoice: #000000

Patient Information:
[Patient Full Name]
[Patient Address]
[Phone Number]

Description of Service	Date of Service	Original Amount	Refund Amount
[Service Name/CPT Code]	[MM/DD/YYYY]	$0.00	($0.00)
[Reason for Refund]	-	-	($0.00)
		Total Refund Amount:	**($0.00)**

Refund Method: [Check / Credit Card / Original Payment]
Transaction ID: [Reference Number]
Authorized By: [Provider Name/Administrator]

Notes: This refund is issued due to [overpayment / insurance adjustment / service cancellation]. Please allow 5-10 business days for the credit to appear on your statement.