URGENT CARE CENTER

REFUND INVOICE

Date: _____

Facility Information:
[Facility Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Patient Information:
Name: _____
ID: _____
DOB: _____

VISIT SUMMARY

Date of Service	Invoice #	Reason for Refund	Original Paid
_____	_____	_____	$ _____

REFUND DETAILS

Description of Adjustment	Amount
Overpayment / Insurance Adjustment	$ _____
Duplicate Payment	$ _____
Service Cancellation	$ _____

Total Refund Amount: $ _____

Method: [ ] Check [ ] Credit Card [ ] Original Payment Method

AUTHORIZATION

Billing Manager Signature: _____

Date Processed: _____

Note: Refunds for credit card transactions may take 5-10 business days to appear on your statement. For questions regarding this refund, please contact the Billing Department.