**REFUND / CREDIT MEMO**

[Medical Office Name]
[Address Line 1]
[Phone Number]

**Date:** _____
**Credit #:** _____
**Original Inv #:** _____

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**Patient Information:**
Name: _____
ID: _____
Address: _____
**Payer Information:**
Name: _____
Policy #: _____
Auth #: _____

| Date of Service | Procedure Code (CPT/HCPCS) | Description of Reason for Refund | Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Subtotal: $ _____
Adjustments: $ _____
**Total Refund: $ _____**

**Reason for Adjustment:**
[ ] Overpayment [ ] Insurance Reversal [ ] Duplicate Payment [ ] Service Not Rendered [ ] Other: _____

Authorized Signature: _____ Date: _____

Notes: Credits are applied to outstanding balances unless a check refund is specifically requested.