

FROM:

[Clinical Facility Name]

[Street Address]

[City, State, Zip]

[Phone/Email]

CREDIT MEMO

DATE:

[Date]

CREDIT MEMO #:

[Number]

ORIGINAL INVOICE #:

[Number]

PATIENT INFORMATION:

[Patient Full Name]

[Patient ID / DOB]

[Insurance Provider Group #]

BILL TO / PAYOR:

[Name / Institution]

[Billing Address]

[Contact Information]

Date of Service	Description of Service/Procedure	Reason for Credit	Amount
			\$0.00
			\$0.00

Subtotal Credit: \$0.00

Tax Adjustment: \$0.00

TOTAL CREDIT AMOUNT: \$0.00

NOTES / ADJUSTMENT DETAILS:

[E.g., Overpayment, Insurance Adjustment, Cancelled Service]

Authorized Signature: _____ Date: _____

This credit will be applied to your account balance or issued via check as per facility policy.