

[PRACTICE NAME]

[Address Line 1]
[City, State, Zip]
[Phone Number] | [Email]

CREDIT MEMO

Date: _____
Credit #: _____
Original Invoice #: _____

PATIENT INFORMATION

Name: _____
Patient ID: _____
Address: _____

CREDIT REASON

Insurance Overpayment
 Procedure Adjustment
 Professional Courtesy
 Other: _____

Date of Service	ADA Code	Description of Adjustment	Amount

Subtotal: \$ _____
Tax (if applicable): \$ _____
TOTAL CREDIT: \$ _____

Notes: _____

Authorized Signature: _____ Date: _____

Thank you for choosing [Practice Name].