

HEALTHCARE PROVIDER NAME

123 Medical Plaza, Suite 100
City, State, Zip
Phone: (555) 000-0000

CREDIT MEMO

Memo #: _____
Date: _____
Ref Invoice #: _____

PATIENT INFO:

Name: _____
ID: _____
Address: _____

INSURANCE / PAYOR:

Provider: _____
Policy #: _____
Group #: _____

Date of Service	CPT/HCPCS Code	Description of Adjustment	Credit Amount

Subtotal: \$0.00
Tax/Fees: \$0.00

Total Credit: \$0.00

Reason for Credit:

Authorized Signature: _____ Date: _____

Notice: This credit will be applied to your outstanding balance or issued via refund check as per facility policy.