

CREDIT MEMO

Inpatient Care Services

[Facility Name]
[Address Line 1]
[City, State, Zip]

PATIENT INFORMATION

[Patient Full Name]
ID: [Patient Account Number]
DOB: [Date of Birth]

MEMO DETAILS

Credit Memo #: [000000]
Date Issued: [MM/DD/YYYY]
Original Invoice: [#000000]
Admission Date: [MM/DD/YYYY]

Service Date	Description of Adjustment	Ref Code	Credit Amount
[Date]	[e.g., Room & Board Adjustment]	[Code]	\$0.00
[Date]	[e.g., Pharmacy Credit]	[Code]	\$0.00
[Date]	[e.g., Laboratory Overcharge]	[Code]	\$0.00

Subtotal Credit: \$0.00
Tax Adjustment: \$0.00
Total Credit: \$0.00

REASON FOR CREDIT:

[Enter detailed explanation for clinical or administrative adjustment here]

Authorized Signature: _____ Date: _____

This credit will be applied to your outstanding balance. If your account is paid in full, a refund check may be issued per facility policy.