

# CREDIT MEMO

**Provider/Facility Name**

Street Address

City, State, Zip

NPI: \_\_\_\_\_

**Memo #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Original Invoice #:** \_\_\_\_\_

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**PATIENT INFORMATION:**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Account #: \_\_\_\_\_

**BILL TO / INSURANCE:**

Payer Name: \_\_\_\_\_

Policy ID: \_\_\_\_\_

Claim ID: \_\_\_\_\_

Date of Service	CPT/HCPCS Code	Description of Adjustment	Amount

Subtotal Credit: \$ \_\_\_\_\_

Tax (if applicable): \$ \_\_\_\_\_

**TOTAL CREDIT AMOUNT: \$ \_\_\_\_\_**

**Reason for Credit:**

Overpayment  Insurance Re-adjudication  Billing Error  Provider Discount

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This credit will be applied to the outstanding balance or issued as a refund according to facility policy.