

[Consultant Name/Practice]

[Medical License Number]

[Address Line 1]

[City, State, Zip]

[Email/Phone]

CREDIT MEMO

Date: [MM/DD/YYYY]

Memo #: [CM-000]

Original Invoice #: [INV-000]

CREDIT TO:

[Client Name / Institution]

[Billing Address]

[City, State, Zip]

[Contact Name]

REFERENCE DETAILS:

Patient Ref/ID: [Ref Number]

Case/File #: [Case Number]

Reason for Credit: [Brief Description]

Description of Service Credited	Date of Service	Amount
[Consultation/Review/Expert Witness Service Name]	[MM/DD/YYYY]	\$0.00
[Administrative/Adjustment Reason]	-	\$0.00

Subtotal: \$0.00

Tax/Adjustment: \$0.00

TOTAL CREDIT: \$0.00

Notes: This credit will be applied to your outstanding balance or future billings unless a refund is requested.

Authorized Signature: _____ Date: _____