

[Hospital Name]

[Department/Billing Unit]

[Street Address]

[City, State, Zip]

[Phone Number]

CREDIT MEMO

Memo #: [000000]

Date: [MM/DD/YYYY]

PATIENT INFORMATION

Name: [Patient Full Name]

ID/MRN: [000-00-000]

Account #: [000000000]

REFERENCE INFORMATION

Original Invoice #: [000000]

Original Date: [MM/DD/YYYY]

Reason: [Insurance Adjustment / Overpayment / Billing Error]

Service Date	Description of Service/Adjustment	CPT/HCPCS Code	Credit Amount
[Date]	[Description]	[Code]	\$0.00
[Date]	[Description]	[Code]	\$0.00

Subtotal Credit: \$0.00

Tax Adjustment: \$0.00

TOTAL CREDIT: \$0.00

Notes: [Internal memo notes regarding the credit authorization.]

This credit will be applied to the patient's outstanding balance or issued as a refund check within [Number] business days.

Authorized Signature: _____ Date: _____