CREDIT MEMO

[Facility Name]
[Street Address]
[City, State, Zip]
[Phone Number]

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

BILL TO

[Patient/Payer Name]
[Billing Address]
[City, State, Zip]
ID: [Patient ID/Policy #]

PROVIDER INFORMATION

NPI: [0000000000]
Tax ID: [00-0000000]
Attending: [Physician Name]

Service Date	CPT/HCPCS Code	Description of Service	Amount Credit
[Date]	[Code]	[Service/Procedure Name]	$0.00
[Date]	[Code]	[Service/Procedure Name]	$0.00

Subtotal: $0.00
Adjustments: $0.00
Total Credit Amount: $0.00

REASON FOR CREDIT

[Enter adjustment reason: e.g., Insurance overpayment, billing error, or service cancellation]

This credit will be applied to your account balance. If this results in a refund, please allow 14 business days for processing. For billing inquiries, contact the business office at [Phone Number].