[CLINIC NAME] PEDIATRICS

[Address Line 1]
[City, State, Zip]
Phone: [Phone Number]

CREDIT MEMO

Date: _____
Credit #: _____
Original Invoice #: _____

CREDIT TO:

Guardian Name: _____
Patient Name: _____
Patient DOB: _____

INSURANCE INFORMATION:

Provider: _____
Policy ID: _____

Service Date	Description of Service / Reason for Credit	Qty	Unit Price	Amount

Subtotal: $ _____
Tax: $ _____
Total Credit: $ _____

Reason for Credit: â–¡ Insurance Overpayment â–¡ Duplicate Billing â–¡ Service Adjustment â–¡ Other: _____

Authorized Signature: _____

Thank you for choosing our clinic for your child's healthcare needs.