CREDIT MEMO

Pharmacy Name
Street Address
City, State, Zip
Phone: (000) 000-0000

Memo #: _____
Date: _____
Original Inv #: _____

CUSTOMER / PATIENT Name: _____
Address: _____
ID/DOB: _____
REASON FOR REFUND [ ] Returned Medication
[ ] Insurance Adjustment
[ ] Overpayment / Copay Correction

NDC / Item #	Description / Prescription #	Qty	Unit Price	Total

Subtotal: $_____
Tax: $_____

Total Credit: $_____

NOTES / REMARKS

Pharmacist Signature: _____
Recipient Signature: _____

This credit memo is for pharmacy internal records and patient reconciliation only.