

[Physician Name/Clinic Name]

[Address Line 1]

[City, State, Zip]

[Phone Number]

CREDIT MEMO

Date: _____

Memo #: _____

PATIENT / BILL TO:

Patient ID: _____

ORIGINAL REFERENCE:

Original Invoice #: _____

Date of Service: _____

Insurance Provider: _____

Description of Adjustment / Reason for Credit	Amount
[e.g., Insurance Overpayment / Provider Write-off]	\$ 0.00
_____	_____
_____	_____
_____	_____

Subtotal: \$ _____

Total Credit: \$ _____

NOTES:

Authorized Signature: _____

This credit will be applied to the patient's outstanding balance or issued as a refund as per clinic policy.