CREDIT MEMO

Surgical Center Name
123 Medical Plaza, Suite 400
Phone: (555) 000-0000

Memo #: _____
Date: _____
Original Invoice #: _____
Patient Account #: _____

BILL TO

Recipient Name / Insurance Co.
Address Line 1
City, State, Zip

PATIENT/CASE INFORMATION

Patient Name: _____
Date of Service: _____
Physician: _____

Code/SKU	Description of Credit (Procedure/Supply/Adjustment)	Qty	Unit Price	Total Credit

REASON FOR CREDIT

[ ] Billing Error
[ ] Insurance Adjustment
[ ] Returned Unused Supplies
[ ] Other: _____

Subtotal Credit: $0.00
Tax/Fees Adjustment: $0.00
Total Credit: $0.00

Authorized Signature: _____ Date: _____

This credit will be applied to your account balance or issued as a refund according to facility policy.