CREDIT MEMO

[Urgent Care Center Name]
[Clinic Address Line 1]
[City, State, Zip]
[Phone Number]

CM Number: _____
Date: _____
Reference Invoice: _____

PATIENT INFORMATION
[Patient Full Name]
[Patient ID / DOB]
[Address Line 1]
[City, State, Zip]

BILLING PARTY (IF DIFFERENT)
[Insurance Carrier or Guarantor]
[Policy / Group Number]
[Claim Number]

Service Date	Description of Adjustment / HCPCS Code	Qty	Unit Price	Credit Amount

Subtotal Credit: $0.00
Tax / Adjustments: $0.00
TOTAL CREDIT: $0.00

REASON FOR CREDIT

Note: This credit will be applied to your outstanding balance or issued as a refund according to provider policy.

Authorized Signature: _____ Date: _____