Patient Refund Request Form

1 Date Prepared: _____

2 Prepared By/Ph #: _____ 3 Department: _____

4 Patient Name: _____
(Last) (First)

Refund to:

5 Name: _____
(Last) (First)

6 Address: _____

_____

7 Case #: _____ Case #: _____

8 Invoice #: _____ Invoice #: _____

9 Doctor #: _____ Doctor #: _____

10 Amount: _____ Amount: _____

11 Date of Service: _____ Date of Service: _____

12 PRPY: _____ 13 PMT DTL: _____ PRPY: _____ PMT DTL: _____

Please Check Reason For Refund: 14 **Total Refund Due**: _____

15 ____ Overpayment ____ Paid in Error ____ Duplicate Payment ____ No Co-Pay Due

16 ____ Adjustments: _____

17 ____ Do Not Transfer to Hospital Account 18 ____ Patient Address Verified

REFUNDS WILL NOT BE PROCESSED WITHOUT THE PROPER SIGNATURE(S)

Supervisor/Assistant Director Name: _____
Supervisor/Assistant Director Signature: _____
Approval Date: _____

NOTICE
Refunds under $500.00 require Supervisor signature.
Refunds over $500.00 require Assistant Director Signature

EXAMPLE - A

Revised 12/8/2010