1 Patient CREDIT CARD Refund Request Form

1 Date Prepared: _____

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

4 Patient Name: _____
(Last) (First)

5 Type of Card: Visa ____ Master Card ____ Discover ____ AmExpress ____

6 Card Number: _____ - _____ - _____ - _____ **7 Exp Date:** _____

Card Holders Information:

8 Billing Zip Code _____ **9 Card Holders Full Name** _____

10 Case #: _____ Case #: _____

11 Invoice #: _____ Invoice #: _____

12 Doctor #: _____ Doctor #: _____

13 Amount: _____ Amount: _____

14 Date of Service: _____ Date of Service: _____

15 PRPY: _____ 16 DTL: _____ PRPY: _____ DTL: _____

17 Please Check Reason For Refund: **18 Total Refund Due:** _____

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

19 ____ Adjustments: _____

20 ____ Do Not Transfer to Hospital Account 21 ____ Patient Credit Card Infomation Verified

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

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

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

EXAMPLE - M

Revised 12/8/2010