**Add logo here  
  
Refund Request**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient name:** |  |  | **DOB:** |  |
|  |  |  | **MRN:** |  |

Please refund:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient or insurance:** |  |  | **Total amount:** |  |

|  |  |
| --- | --- |
| **Claim(s) reference** (Claim #, DOS, CPT Code, etc.) |  |

Requested by:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Amount:** |  |  | **Refund type:** | Check  Credit card |  | **Posting date:** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Requested by:** |  |  | **Processed by:** |  |  | **Posted by:** |  |

|  |  |
| --- | --- |
| **Signature:** |  |

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