Refund Request Form

Request Date_____ **Doctor**_____

Office Name_____

Patient Name_____

Patient Mailing Address_____

_____

_____

Reason (Please Circle): Credit Ins Overpayment Failed Tx Pt Overcharge

Check Amount $_____

_____FOR A/R USE ONLY_____

Check #_____ Mailed On_____

_____ _____

A/R Specialist Signature **Ori Bekerman Signature**