Refund Request Form

Request Date: _____

Office Name: _____ **Treating Provider:** _____

Patient Name: _____ **Patient ID:** _____

Patient/Insurance (Circle)

Mailing Address:

_____

Notes:

_____

_____

Reason (Circle): Credit Failed TX Pt Overcharge Ins Overcharge

Amount $_____ **Refund Type (Circle):** Check Credit Card Third Party Finance

_____**FOR A/R USE ONLY**_____

Check _____ **Mailed On:** _____

_____ _____

A/R Specialist Signature **Nandish Patel Signature**