(Practice Name)

INTERNAL REFUND REQUEST

Acct #: _____ Patient Name: _____

Guarantor/Insured Name: _____

Address: _____

_____

Refund Amt: $ _____ Date of Service: _____

Reason: □ Insurance Paid
□ Patient Overpayment
□ Co-payment not required for service
□ □Other _____

* Is there a balance on account after this refund is made? □ No □ Yes

* Are there other family member accounts that have a balance or credit? □ No □ Yes

(Refunds are generally not made until there is a zero balance on all family accounts.)*

Requested by: *(your initials)*:_____ Date: _____

Refund check #: _____ Date Generated: _____ Bookkeeper: _____