

Clinic Site: Choose an item.

Patient Name:

Account Number:

Date of Refund Request:

|  |  |  |
| --- | --- | --- |
| **Date(s) of Service** | **Encounter(s)** | **Amount** |
|  |  |  |
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|  |  |  |
| Total: |  | $ 0.00 |

**Issue To*:***

(*Name*)

(*Address*)

(*City,State,Zip*)

Submitted By:

Verified By:

Approved By:

**Reason for Refund**: Click here to enter text.

Voucher Number:

Check #:

Check Issued By: