



Patient Name: _____ Medical Record #:

F/C: _____ Date(s) of Service: _____ Date of Injury:

Claim #: _____ I.D. #/SSN:

Reason: _____ Refund Amount: \$

REFUND PAYABLE TO: _____
Attn: _____
ADDRESS: _____
CITY/STATE/ZIP: _____

Account #	Billing Unit	Amount
		Fac:
		Pro:
		Fac:
		Pro:
		Fac:
		Pro:
		Fac:
		Pro:

REQUIRED INFORMATION

Patient Refund: _____ Screen-Print of CHRSUM & ACCTDOC
 _____ Screen-Print of Foundation (if applicable) or Hold Harmless (if reissue)
 _____ Patient Receipts

Insurance Refund: _____ Screen-Print of CHRSUM & ACCTDOC
 _____ Copy of Check and EOB, refund request letter being refunded
 _____ Screen-Print of Foundation and Medi-Cal/Medi-Care eligibility

LBO/CBO Requestor: _____ Ext: _____ Date: _____

LBO Manager: _____ Ext: _____ Date: _____

Authority Levels Are Based on Approved FDA Limits:

ASU Supervisor: _____ Ext: _____ Date: _____

ASU Manager: _____ Ext: _____ Date: _____

PBS Director: _____ Date: _____

VP of Finance: _____ Date: _____