NORTHERN NEVADA
Public Health

CCHS REQUEST FOR REFUND

Refund Request Date: ____________________ **Date(s) of Service** ______________________

Client Name: ______________________________ **Client Number:** ________________

Contact Name: ____

Phone Number: ____

EMAIL Address: ____

Make Check Payable to: ____

Mailing Address: ____

____
City State Zip

Original Payment: $______________ made via: Cash Check Credit Card Debit Card

Refund Requested: $______________
Reason for Refund:

____ ________________________
Signature Date

- -

FOR INTERNAL USE ONLY

Date(s) of Service ___________ Insurance Billed? Yes No Insurance Paid? Yes N/A

_____**Clinic Office Supervisor Approval**

_____**Public Health Nursing Supervisor Approval**

_____**Division Director Approval**

_____**FCO Approval** **AHSO Approval:**____

Final Refund Amount: $____________(FCO calculates) Cash, Check or Debit Card requires Voucher
If via credit card, must be on card ending in _______

Notes:

CCHS Supporting Documentation Checklist

- Patagonia printout reflecting payment history (payment amount, posting date, balance due) (CCHS)
- Copy of Cashier Postings by Program report (CCHS)
- Copy of Cash Desk Transmittal (AHS)
- If payment made by check, copy of original check received and deposited (AHS)
- If payment made by credit or debit card, copy of card receipt and batch total (AHS)
- Any other documentation that supports request for refund