

REFUND REQUEST

CLINIC NAME AND ADDRESS	STATE PROVIDER NUMBER
	AMOUNT OF REFUND REQUESTED
NAME OF CLIENT	CLIENT CASE NUMBER
NAME OF PAYEE (IF DIFFERENT FROM CLIENT)	COUNTY MISCELLANEOUS RECEIPT NUMBER AND DATE
MAIL REFUND TO: NAME _____ ADDRESS _____ _____	CLINIC CONTACT PERSON: NAME _____ TELEPHONE NUMBER _____
APPROVED: SIGNATURE _____ TITLE _____	
REASON FOR REFUND	
OTHER	

ATTACH LEGIBLE COPIES OF ALL RECEIPTS, CANCELLED CHECKS, CORRESPONDENCE, ETC. TO THIS REFUND REQUEST FORM AND SUBMIT TO:

REVENUE GENERATION SECTION
FISCAL SERVICES DIVISION
2415 WEST SIXTH STREET
LOS ANGELES, CALIFORNIA 90057