UCR | HEALTH

Compliance Rebill Request

Requested by: _____ Date: _____

Department	
Provider Number	
Medical Record Number	
Patient Name	
HIC	
ICN#	
Date of Service	
Billed CPT	
Correct CPT requested	

To be completed by Revenue Management

Original payment	
Corrected CPT billed	
Allowance	
Paid	
Refund	
Check Number	
Check Date	

Compliance Approval: _____

Date: _____

Revenue Cycle Manager Approval: _____

Date: _____

Original: Compliance
Copy: Clinical Affairs

Rev. 08/17