LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

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 DA
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