Redwood Coast Regional Center Billing Adjustment Request

Please fax completed form to (707) 462-6579 Date:

Contact Name: Email:

Vendor Name: Phone number:

Vendor Number: Service Code:

Client Name:

Client UCI Number: Client Authorization Number:

Service month: Year: Original invoice number:

☐ Refund ☐ Additional billing

Sub Code: Units Billed Originally: Additional Units to Bill:

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Brief reason for your request:

For Redwood Coast Regional Center Fiscal Staff Only

Units/Dollars Authorized:

Amount Paid: $ Units:

Approved: YES NO Approved by: Date:

Action needed: Reissue Only Reverse & Reissue Reverse Only

Denied: YES NO Denied by: Date:

Reason for denying request: