

Account Write-off Request Form

Date: _____

Client's Name: _____

Responsible Party: _____

Amount of Write-off: _____

Reason for Write-off:

- Medicaid reversal
- Charge is over 1 year old and non-payable
- Responsible party cannot be located
- Responsible party is deceased
- Responsible party has filed bankruptcy
- Account was turned over to collections and deemed uncollectible
- Other

Classification of Write-off: Bad Debt _____

Rejected Claim _____

Write-off _____

Other _____

Person Requesting Write-off: _____

Write-off Request ____ Approved ____ Denied

Executive Director Signature: _____

Comments:
