



Missouri Department of Revenue
Employer Withholding Tax Refund Request

Department Use Only
(MM/DD/YY)

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Reporting Period
(MM/YY)

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Missouri Tax I.D.
Number

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Federal Employer
I.D. Number

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Please logon to the Online Credit Inquiry System to verify all overpayments on your account prior to completing this form.

Company	Business Name		Overpay Amount	
	Business Address		Telephone Number (____) ____ - ____	
	City	State	Zip Code	

Credit	Tax Year _____ <input type="checkbox"/> January <input type="checkbox"/> February <input type="checkbox"/> March <input type="checkbox"/> April <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> August <input type="checkbox"/> September <input type="checkbox"/> October <input type="checkbox"/> November <input type="checkbox"/> December
	Tax Year _____ <input type="checkbox"/> January <input type="checkbox"/> February <input type="checkbox"/> March <input type="checkbox"/> April <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> August <input type="checkbox"/> September <input type="checkbox"/> October <input type="checkbox"/> November <input type="checkbox"/> December
	Tax Year _____ <input type="checkbox"/> January <input type="checkbox"/> February <input type="checkbox"/> March <input type="checkbox"/> April <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> August <input type="checkbox"/> September <input type="checkbox"/> October <input type="checkbox"/> November <input type="checkbox"/> December
	Tax Year _____ <input type="checkbox"/> January <input type="checkbox"/> February <input type="checkbox"/> March <input type="checkbox"/> April <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> August <input type="checkbox"/> September <input type="checkbox"/> October <input type="checkbox"/> November <input type="checkbox"/> December

Provide a detailed description of the reason for overpayment. (Required)

Signature	Signature (Required)	Date (MM/DD/YYYY) ____ / ____ / ____

Form 4854 (Revised 12-2014)

Mail to: Taxation Division
P.O. Box 3375
Jefferson City, MO 65105-3375

Phone: (573) 751-7200
Fax: (573) 522-6816
E-mail: withholding@dor.mo.gov

Visit <http://dor.mo.gov/business/withhold/> for additional information.



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