



Employee Assistance Program & Training

470 Forest Avenue Ste 305
Portland, ME 04101

Office 800.769.9819
Fax 207.773.5337

Billing Form

To be mailed or faxed, do not email

EMPLOYER:		PROVIDER/VENDOR- PLEASE MAKE CHECK PAYABLE TO:	
Company Name: _____		Agency: _____	
Work Site Location: _____		Name/Address: _____	
		Phone Number: _____	
EMPLOYEE/ HOUSEHOLD MEMBER:		Last: _____	First: _____

Critical Incident Response	DOT/SAP Assessment	Training / On-site Consult
Date: _____	Date: _____	Date: _____
Travel Time: _____	Assessment Hours: _____	Training Hours: _____
On-Site Time: _____	Follow-up Hours: _____	Consult Hours: _____
Total \$ Amount: _____	Total \$ Amount: _____	Mileage: _____
		Total \$ Amount: _____

EAP FACE-TO-FACE Visits	Amount Due	Check if Case Closed
Initial Visit Date: _____		<input type="checkbox"/>
Follow-up Date: _____		<input type="checkbox"/>
Follow-up Date: _____		<input type="checkbox"/>
Total \$ Amount Due: _____		<input type="checkbox"/>

We encourage you to bill after each session. Billing Forms received after 45 days from the first date of service will be subject to a 100% penalty.

OFFICE USE ONLY
Work Force/EAP Authorized Signature
Amount: _____