

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	Assessment	Training
Time: _____	Hours: _____	Hours: _____
On-Site	Follow-up	Consult
Time: _____	Hours: _____	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: _____