



EAP PROVIDER REIMBURSEMENT FORM

AUTHORIZATION # _____ PATIENT NAME _____

EMPLOYER _____ AUTHORIZED # OF SESSIONS _____

DATE OF SESSION	TIME IN/TIME OUT	SESSION #	\$FEE	FOR MATRIX USE

TOTAL CHARGE _____

ADDITIONAL COMMENTS:

PROVIDER NAME _____ PROVIDER SIGNATURE _____

BILLING NAME _____

BILLING ADDRESS _____

SS# _____ OR FEDERAL TAX ID # _____

PLEASE SUBMIT THIS FORM MONTHLY FOR EACH MATRIX EAP CLIENT, WHETHER OR NOT THE CASE HAS CLOSED.

Return to: Matrix Psychological Services
2 Easton Oval, Suite 450
Columbus, OH 43219

800-886-1171

FAX 614-475-9821