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 NO LESS THAN MONTHLY FOR EACH MATRIX EAP CLIENT, WHETHER OR NOT THE CASE HAS CLOSED.

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

Claims can be submitted via Email, Mail of Fax.

Email: Networkstaff@matrixpsych.com

800-886-1171 **FAX 614-475-9821**