EAP PROVIDER REIMBURSEMENT FORM

AUTHORIZATION # _____ PATIENT NAME _____

CLIENT'S
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.

**ALL SESSIONS MUST BE AT LEAST 7-10 DAYS APART. We can approve sessions within that time-frame, IF NEEDED **

Claims can be submitted via Email, Mail of Fax.

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