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 _____

NAME TO PUT ON REIMBURSEMENT CHECK _____

BILLING ADDRESS _____

SS# _____ OR FEDERAL TAX ID # _____

PLEASE SUBMIT THIS FORM MONTHLY FOR ALL MATRIX EAP PATIENTS, REGARDLESS OF CASE STATUS. BILLS SENT AFTER 6 MONTHS (180 DAYS) WILL NOT BE REIMBURSED.

**ALL SESSIONS MUST BE AT LEAST 7 DAYS APART. We *strongly* recommend no closer than bi-weekly. We can approve sessions within that time-frame, IF NEEDED **

Claims can be submitted via Email, Mail of Fax.

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

P: 800-886-1171

F: 614-475-9821

Email: Networkstaff@matrixpsych.com