**This form must be submitted within thirty (30) days of *EACH* date of service. Please type or print legibly.**

EAP CONSULTANTS, LLC
WELL-BEING RESTORED℠

# INVOICE

MAKE CHECK PAYABLE TO _____
**(name must match the tax ID on file with the IRS)**

SS or TAX ID #_____ INC.? □ YES □ NO

BILLING ADDRESS_____

CITY_____STATE_____ZIP_____

COUNSELOR NAME_____PHONE #_____
(If different than "make check payable to")

**********

CLIENT NAME_____AUTHORIZATION #_____

CLIENT DOB_____EMPLOYEE NAME (if different from client)_____

NAME OF EMPLOYER PROVIDING EAP BENEFIT_____

**********

**DATES CLIENT SEEN AND CHARGES :**
**(do not include previously invoiced dates)**

| DATE | FEE | ( ☑ ) CHECK IF NO-SHOW OR LATE CANCELLATION |
|---|---|---|
| _____ | ( ) | **EAPC does not pay for no shows or late cancellations** |
| _____ | ( ) | |
| _____ | ( ) | **TOTAL AMOUNT DUE:**_____ |
| _____ | ( ) | |
| _____ | ( ) | _____ COUNSELOR'S SIGNATURE: |
| _____ | ( ) | DATE:_____ |

**Total number of EAP visits to date:**_____

**INVOICES MUST BE SUBMITTED WITHIN 30 DAYS OF EACH DATE OF SERVICE TO BE ELIGIBLE FOR REIMBURSEMENT.**
**ATTACH THE CLOSED CASE FORM IF THIS IS THE FINAL INVOICE FOR THIS CLIENT.**

**PLEASE MAIL OR FAX TO:** **EAP Consultants, LLC**
**1850 Parkway Place, Suite 700**
**Marietta, GA 30067**
**Fax # 770-953-3174**

**You may securely complete and submit closed case forms at:**
**www.eapconsultants.com**
**Click on the Clinicians tab.**