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

ESPYR
IMAGINE. ACHIEVE. CONQUER.

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
_____	( )	**ESPŸR 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:

ESPŸR
1850 Parkway Place, Suite 700
Marietta, GA 30067
Fax # 770-953-3174

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