MAZZITTI & SULLIVAN
EAP

EAP INVOICE

Please send your completed form **within 14 days** of the client's date of service. Interim billing is encouraged!
All fields are required – please type. Do not include any PHI on this form.

Email this form to: info@mseap.com

Your Invoice/Reference #:	
EAP Client Code: *(from top left of Referral Authorization form)*	
Date(s) of Service:	
Appointment Type:	☐ In-Person ☐ Virtual/Online ☐ Telephonic
EAP Provider/Agency Name:	
Counselor Name:	
Full Mailing Address: *(Required even if you are receiving direct deposit)* ☐ Check if NEW address!	
☐ **Check this box if this is the first session, and be sure to include the Consent Form!**	
Reimbursement Rate:	$60.00 per session
Amount Requested:	$
Your Contact Information, if we have questions:	Name: _____ Phone: _____ Email: _____

APPOINTMENT SUMMARY AND RECOMMENDATIONS – **REQUIRED**	
Therapist Recommendations:	____ Client has been discharged – no further recommendations ____ Client planning to return for further sessions ____ Client referred to other Outpatient Care ____ Client referred to Inpatient Care ____ Client referred to Other Resources

Allow 2-4 weeks for processing from date of receipt.