AdvantageEAP
EMPLOYEE ASSISTANCE PROGRAM

Billing Statement

Patient Information

Patient Name: _____ Advantage EAP Record #: _____
Advantage EAP Client Company: _____

EAP Affiliate/Agency Payment Information

Check Payable to: _____ FEIN/SS#: _____
Check Mailing Address: _____
City: _____ State: _____ Zip: _____

Please Note: Unauthorized sessions will not be reimbursed. Bills must be submitted within 60 days of the last contact with the client.

Session	Fee
1	
2	
3	
4	
5	
6	
7	
8	

Total $ _____

Clinician's Signature _____ Date _____

Submit bills to: Advantage EAP
2296 County Line Road
Algonquin, IL 60102

Direct questions to:
Lee Ann Stepina, EAP Coordinator
(847)458-4674

For Advantage EAP use only. Please do not write below this line.

Advantage EAP Manager _____ Advantage EAP Case # _____

Date Received _____ Date Paid _____ Check # _____