LifeSpring Health Systems

Affiliate Monthly Billing Form

EAP COMPANY Name _____

Billing for Month of _____

Affiliate Name _____

Address _____

City _____

State _____ **Zip** _____ **Phone** _____

Federal ID # _____ **Contact Person** _____

COUNSELING SERVICES

Employee Name	Employer	☑1Check if Supervisor Referral	Client Name	Client Birth Date	Relationship E=Employee S=Spouse C=Child	DSM DX Code	Date Case Opened	Service Date(s)	# Hours Billed	Amount Due

Subtotal COUNSELING amount due _____

CONSULTATION SERVICES

Provider Name	Date	Description of Services	# of Hrs	Amount Due

Subtotal CONSULSTATION Amount due _____

TOTAL AMOUNT DUE FOR THIS MONTH _____

Mail Completed Form to:
EAP Contract Billing Services
LifeSpring Health Systems
P.O. Box 769
Jasper, Indiana 47547--0769