



Aurora Health Care®
Employee Assistance Program

Invoice

****Please note that each Employer may have different EAP Services available. Refer to the Intake Information page that was faxed to you under 'Contract Type' for this Client's benefit. ****

Client Name (or Employer if Onsite Service): _____

<u>Client EAP Services</u>				<u>Onsite Employer Services</u>	
	Date of Service	Date of Invoice Submittal	√ if Case Closed	<u>Service Type</u> (Check one and provide Description)	
Consultation #1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Crisis Response	
Consultation #2	_____	_____	<input type="checkbox"/>		
Consultation #3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Training	
Short-Term #1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Promotional Event	
Short-Term #2	_____	_____	<input type="checkbox"/>		
Short-Term #3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> Onsite Consultation	
Short-Term #4	_____	_____	<input type="checkbox"/>		
Short-Term #5	_____	_____	<input type="checkbox"/>		
Short-Term #6	_____	_____	<input type="checkbox"/>	# of Employees in Attendance _____	
Short-Term #7	_____	_____	<input type="checkbox"/>	Date _____	
D.O.T. Assessment ONLY Initial Evaluation Date: _____ Contracted Case Rate: _____				Contracted Rate per Hour _____	
				Onsite Hours _____	
				Travel Hours _____	
				Total Hours _____	

EAP Counselor/ Affiliate: _____

Clinic Name: _____

Billing Address: _____

City, State, Zip: _____

Phone Number: _____

Invoice and required paperwork (see box below) must be submitted within thirty (30) days of each EAP Service to:

Aurora Employee Assistance Program
Attn: Billing
FAX: 920-451-5057
2640 N. 6th Street
Sheboygan, WI 53083
Call with any questions: 888-389-3299

Initial Submission:	265- Data Entry Form 273- Statement of Understanding 282- Invoice
Ongoing Case:	282- Invoice Only
Case Closed:	276- Case Closing Form 281- Freedom of Choice (if needed) 282- Invoice