TriHealth EAP®
Billing/Closure Form

Please complete all sections to avoid delays in payment.

Client Last Name:_____ Client First Name: _____

Client ID#: _____ Tax ID#: _____

Make Check Payable to: _____

Mailing Address:_____

Service Dates:					

Total number of sessions delivered listed on this form: _____

EAP Service delivered (choose only one):

○ EAP Services only ○ EAP Counseling & Collateral Referral (self-help or MD) ○ EAP Assessment & Referral

○ Freedom of Choice Affidavit: If a referral is necessary and the client elected to remain with affiliate therapist utilizing either their insurance or self-pay, affiliate attests that other options were discussed with client including advantages and disadvantages of each option and the cost of each option.

Problem Type (choose one):		Well-Being Support Discussed
○ Workplace Problem	○ Other Life Stressors	☐ Proper Diet/Nutrition
○ Family	○ Relationship/Marital	☐ Importance of Sleep/Hygiene
○ Health	○ Traumatic Event	☐ Need for Regular Exercise (MD approved)
○ Legal	○ Substance Abuse/Addiction	☐ Need for Preventive Screenings
○ Mental/Emotional	○ Nicotine Addiction	☐ Work/Life Resources on TriHealth EAP website

☐ INTERIM BILLING ☐ FINAL BILLING

Affiliate Signature: _____ Date:_____

Return Form by one of two ways:

Email: TriHealthEAPBilling@trihealth.com Fax: 513-852-8533

OFFICE USE ONLY

Assessment Rate: $_____ Counseling/Case Management Rate: $_____

TriHealth EAP TC Signature:_____ Date _____

BILLING DEPT USE ONLY: Date Posted:_____ Posted by: _____

☐ FEE FOR SERVICE