Northern Light
Work Force

Employee Assistance Program & Training

Office 800.769.9819
Fax 207.773.5337

Billing Form

To be mailed or faxed, do not email

EMPLOYER:	**PROVIDER/VENDOR- PLEASE MAKE CHECK PAYABLE TO:**
Company Name: ____________	Agency: ____________
Work Site Location: ____________	Name/Address: ____________
	Phone Number:

EMPLOYEE/ HOUSEHOLD MEMBER:	Last:	First:

Critical Incident Response	**DOT/SAP Assessment**	**Training / On-site Consult**
Date: ____________	Date: ____________	Date: ____________
Travel Time: ____________	Assessment Hours: ____________	Training Hours: ____________
On-Site Time: ____________	Follow-up Hours: ____________	Consult Hours: ____________
Total $ Amount: ____________	Total $ Amount: ____________	Mileage: ____________
		Total $ Amount:

EAP FACE-TO-FACE Visits	**Amount Due**	**Check if Case Closed**
Initial Visit Date:		☐
Follow-up Date:		☐
Follow-up Date:		☐
Total $ Amount Due:		☐

We encourage you to bill after each session. Billing Forms received after 45 days from the first date of service will be subject to a 100% penalty.

OFFICE USE ONLY
Work Force/EAP Authorized Signature
Amount: