Northern Light℠
Work Force

Employee Assistance Program & Training
707 Sable Oaks Drive, Suite 125
South Portland, ME 04106

Office 800.769.9819
Fax 207.773.5337

Billing Form

To be mailed or faxed, do not email; Processed only with signed case report forms attached.

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

EMPLOYEE/ HOUSEHOLD MEMBER: Last name: First name:

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: