STUECKER & ASSOCIATES INC.

www.stueckerandassoc.com

Billing Form-To be completed by EAP Counselor and emailed to bookkeeper@stueckerandassoc.com

Provider Name _____ **EIN or SS#** _____

Billing Address _____ **Client Name** _____

_____ **Employer** _____

Phone _____

Referral Information:

Did you refer this person to resources and/or for long-term treatment? ☐Yes ☐No

If "yes", provide

Referral/Resource:

- ☐ Hospitalization Inpatient
- ☐ Intensive Outpatient (IOP)
- ☐ Psychiatric Consultation
- ☐ Outpatient Counseling
- ☐ Legal
- ☐ Financial
- ☐ Medical
- ☐ Support Group
- ☐ Other _____
- ☐ Work Life _____

Referred to: _____ **Location:** _____ **Phone:** _____

Did Client Accept the Referral? ☐Yes ☐No

Please Note: If there is a risk of violence to self or others, contact SAI immediately following the session.

Date of Service	Time	Duration	In Attendance

In Attendance Key

C = Child

E = Employee

A = Adult household member

Note the # of each in attendance. Example:
C-2, A-1, E-1 = 2 Children, 1 Adult household member, & 1 Employee attended the session

I certify that the above accurately represents the services I have provided this month on behalf of SAI.

_____

Counselor Signature **Date**

Note: Counseling Sessions must be billed within 30 days of each date of service. Please forward completed form to Stuecker & Associates Inc. or email to bookkeeper@stueckerandassoc.com.