TriHealth

TriHealth EAP®
Billing/Closure Form

Please complete all sections to avoid delays in payment.

Client Last Name: _____ Client First Name: _____

Client ID#: _____ Provider 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: corporatehealthbilling@trihealth.com Fax: 513 852 3058

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