



**American Behavioral
Employee Assistance Program**

Invoice for EAP Service

Remittance Payable To: _____

Provider/Organization: _____

Address: _____

Client's Name	Company	Date of Service	Cost Per Session

Total Amount Due _____

I certify that I personally rendered services as listed above. I understand that I must complete and submit the Invoice for Service and Record of Service within 30 days of service in order to be compensated. EAP referrals have a sixty-day expiration.

Signature

Date

Amount Approved for
Payment

Authorizing Officer

Date

550 Montgomery Highway, Suite 300
Birmingham, Alabama 35216
(205) 871-7814
Fax (205) 868-9600
www.americanbehavioral.com