# American Behavioral

## **E**mployee **A**ssistance **P**rogram

### Summary of Service

Name of Client: _____ Date of Service: _____

Authorized number of sessions: _____ Sessions used: _____

Street Address: _____

_____

Employer: _____

Phone Number: _____

Diagnostic Impression: _____

Provider: _____

Comments and Recommendations:_____

_____

_____

_____

_____

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

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