Affiliate Reimbursement Form

Affiliate Name and Phone Number:

Mailing Address:

Affiliate Signature:

Date Invoice Submitted:

Referring EAP Clinician:

Date	Client's Name	Client's Company	Fee	Disposition*

TOTAL FEE:_____

*Outpatient, Day Treatment, Inpatient, EAP Only, Self Help, Referral Declined or Other(specify)

Mail to: Comprehensive EAP, 4 Mount Royal Ave, STE 310, Marlborough, MA 01752, fax to 774-463-3455 or email to jsagor@compeap.com

Following receipt of this invoice, you can expect to receive remittance within 30 days.