Affiliate Reimbursement Form

Affiliate Name and Phone Number: ______________________________

Make Check Payable To: ______________________________

Mailing Address: ______________________________

Affiliate Signature: ______________________________

Date Invoice Submitted: ______________________________

Referring CompEAP 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, 2 Mount Royal Ave, Suite 480, Marlborough, MA 01752

Fax to: 774-463-3455

Email to: billing@compeap.com

Following receipt of this invoice, you can expect to receive remittance within 30 days. For any bill related questions or claim status, please email billing@compeap.com