



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, 4 Mount Royal Ave, STE 310, 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