

WellSpan EAP Referral and Invoice

Date of Intake: _____
Completed By: _____
Referred To: _____

Affiliate Contacted: _____
Forms Faxed: _____
First Scheduled Appointment: _____

Client's Name: _____
(Last) (First) (Middle Initial)

Client's Address: _____
County: _____

Best Phone Number to Reach You At: _____ Home Cell Work

Alternate Phone Number: _____ Home Cell Work

Client May Be Called At: Home Cell Work

Number of EAP Sessions Approved

May Leave a Message At: Home Cell Work

Employer _____

Date of Birth: _____ Gender: M F SSN: _____

Presenting Problem: _____

How Quickly Do You Need To Be Seen: _____

Primary Insurance: _____

Affiliate Invoice

Date: _____ Tax ID or SSN: _____ Evaluator _____

Dates of Service: _____ ; _____ ; _____ ; _____ ; _____

Provider of Service _____

Make check payable to: _____

Mailing Address: _____

Invoice or HCFA 1500 form & Statement of Understanding must be submitted within 60 days of the final session to:

EAP -WellSpan
Attn: Client Services Representative
P.O. Box 1827
York, PA 17405-1827

For WellSpan EAP use:

Date Forwarded to Client Services Department: _____