Aurora Employer Solutions
Employee Assistance Program

Aurora Health Care®

Invoice

Client Name (or Employer if Onsite Service):_____ **Client ID #:** _____

Client EAP Services

	Date of Service	Date of Invoice Submittal	√ if Case Closed
Session #1			☐
Session #2			☐
Session #3			☐
Session #4			☐
Session #5			☐
Session #6			☐
Session #7			☐
Session #8			☐

Please verify the # of Authorized Sessions at the bottom of **Client Data Form**.

D.O.T. Assessment ONLY

Initial Evaluation Date: _____

Contracted Case Rate: _____

Onsite Employer Services

Service Type
(Check one and provide Description)

☐ Crisis Response

☐ Training

☐ Promotional Event

☐ Onsite Consultation

# of Employees in Attendance _____

Date _____

Contracted Rate per Hour _____

Onsite Hours _____

Travel Hours _____

Total Hours _____

EAP Counselor/ Affiliate:_____

Clinic Name:_____

Billing Address:_____

City, State, Zip:_____

Phone Number:_____

Invoice and required paperwork (see box below) must be submitted within thirty (30) days of each EAP Service to:

Aurora Employee Assistance Program
Attn: Billing
FAX: 920-449-7724
2636 Eastern Avenue
Plymouth, WI 53073

Call with any questions: 888-389-3299

Initial Submission:	265- Client Data Form 273- Statement of Understanding 282- Invoice
Ongoing Case:	282- Invoice Only
Case Closed:	276- Case Closing Form 261- Outpatient Referral Letter (if needed) 281- Freedom of Choice (if needed) 282- Invoice