EMPLOYEE RESOURCE SYSTEMS, INC.
BILLING STATEMENT

Patient Information

Patient Name: ____________________________ ERS File #: ______________

ERS Client Company: ____

EAP Affiliate/Agency Payment Information

Check Payable to: ____________________________ FEIN/SS#: ______________

Check Mailing Address: ____

City: ______________________ State: __________ Zip: ______________

Email: ______________________ Phone #: ______________________

PLEASE NOTE: Unauthorized sessions will not be reimbursed. Bills must be submitted within 60 days of the last contact with the client.

Session Date	Fee
1	**$65.00**
2	
3	
4	
5	
6	
7	
8	

TOTAL $____________________

Clinician's Signature ______________________________ **Date** ______________

Submit bills to: Employee Resource Systems, Inc.
29 E. Madison, Suite 1600
Chicago, IL 60602

Direct questions to: Patty Gudas (866) 377-5550 x 6322 or email to pgudas@ers-eap.com
Fax: (312) 269-0309

For ERS Use only. Please do not write below this line.

ERS Case Manager ______________________________ ERS File #______________

Date received______________ Date paid______________ Check # ______________