

INVOICE

Invoice must accompany case paperwork

Invoice Number (Case Number): _____

EAP Counselor Information:

Counselor's Name: _____

Agencies Name: _____
(if applicable)

Billing Address: _____

Phone#: _____

Tax ID# _____

Remit To:

Your Advocate
14915 Broschart Rd
Suite 250
Rockville, MD 20850

Please check the appropriate boxes in the grid below to indicate the status for each appointment.

Date	Attended	Late Cancellation	No Show
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	(
	(((

For Office use Only

Sessions Used: _____ Rate: _____ Total: _____

Clinical Supervisor Approval	APPROVED FOR PAYMENT (NET 30)											
	Signature: _____											
	Date: _____						Amount: _____					
	Div.		Unit		Department				Account Numbers			
	1	0	7	9	0	0	0	0	5	8	5	0