P.O. Box 1827
York, PA 17405
1-800-673-2514 Toll Free
717-851-4493 Fax
www.WellSpan.org/EAP

WellSpan Employee Assistance Program

WellSpan EAP Referral and Invoice

Date of Intake: _____ Affiliate Contacted: _____
Completed By: _____ Forms Faxed: _____
Referred To: _____ First Scheduled Appointment: _____

Client's Name: _____

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**

May Leave a Message At: ☐ **Home** ☐ **Cell** ☐ **Work**

Number of EAP Sessions _____

Employer: _____

Employee's Name (if not client): _____ **DOB:** _____

Client Date of Birth: _____ **Gender:** ☐ M ☐ F

Presenting Problem: _____

How Quickly Do You Need To Be Seen: _____

Primary Insurance: _____

Affiliate Invoice

Date: _____ **Tax ID or SSN:** _____ **Evaluator:** _____

Provider of Service: _____ **NPI:** _____

Service Address: _____

Make check payable to: _____

Pay to Address: _____

Diagnosis or Nature of Illness or Injury - A._____ **B.**_____ **C.**_____ **D.**_____ **E.**_____

Date of Service:	**CPT Code:** 00000	**Date of Service:**	**CPT Code:** 00000
Date of Service:	**CPT Code:** 00000	**Date of Service:**	**CPT Code:** 00000
Date of Service:	**CPT Code:** 00000	**Date of Service:**	**CPT Code:** 00000

Invoice, electronic billing or HCFA 1500 form & Statement of Understanding should be submitted within 60 days of the final session to: **EAP – WellSpan**
Attn: Client Services Representative
P.O. Box 1827
York, PA 17405-1827