



EMPLOYEE ASSISTANCE NETWORK

EAN INVOICE FORM

CLIENT INFORMATION:

Client Last Name: _____ First Name: _____
Case #: _____

PAYMENT INFORMATION:

Name of therapist: _____ Name of agency: _____
Payment made out to: _____
Payment address: _____
City, State, ZIP: _____
Phone #: _____ Tax ID: _____
(if first time billing)

SERVICE PROVIDED

Service	Session Date	# Seen	
Session # _____	_____	_____	_____
Session # _____	_____	_____	_____
Session # _____	_____	_____	_____
Session # _____	_____	_____	_____
Session # _____	_____	_____	_____
Session # _____	_____	_____	_____
Session # _____	_____	_____	_____
Session # _____	_____	_____	_____

Case closed? Yes No

OFFICE USE ONLY:

# of sessions		fee		total \$	CR#	Initials
	X		=			

Please return: 1. EAN Reporting Form 2. EAN Client Screening Form 3. Invoice Form 4. Case Closing Form 5. signed EAN Client Service Agreement within 30 days of authorization end date and mail or fax it to:
EAN - Metropolitan Family Services • One North Dearborn, 10th fl. • Chicago, IL 60602 • Ph 312-986-4249 • Fax 312-986-4187