

EMPLOYEE RESOURCE SYSTEMS, INC.
BILLING STATEMENT

Patient Information

Patient Name: _____ (ERS Record#: _____)
ERS Client Company: _____

EAP Affiliate/Agency Payment Information

Check Payable to: _____ FEIN/SS#: _____
Check Mailing Address: _____
City: _____ State: _____ Zip: _____

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
Fax: (312) 780-6344

Direct questions to: Patty Gudas (866) 377-5550 x 6322
pgudas@ers-eap.com

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

ERS Case Manager _____ ERS Case # _____

Date received _____ Date paid _____ Check # _____



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