

P.O. Box 1827
York, PA 17405
866-227-6527 Toll Free
717-851-4493 Fax
www.wellspaneap.org



WellSpan EAP Referral and Invoice

Date of Intake:
Completed By:
Referred To:

Affiliate Contacted:
Forms Faxed:
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:

Mailing Address:

Date of Service:

CPT Code:

Date of Service:

CPT Code:

Date of Service:

CPT Code:

Date of Service:

CPT Code:

Date of Service:

CPT Code:

Date of Service:

CPT Code:

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**