Preferred EAP®

_____

NATIONAL NETWORK PROVIDER INVOICE

This document – or a HCFA 1500 – is to be completed and submitted to Preferred EAP when EAP services are terminated and accompanying the *NATIONAL NETWORK PROVIDER REPORT*. Failure to provide both documents will result in payment delays. Thank you.

NOTE: PLEASE INCLUDE A COPY OF YOUR **W-9** FORM ALONG WITH THIS INVOICE.

DATE: _____

TO: Michelle Mcevoy, Office Coordinator
Preferred EAP
1728 Jonathan St.
Allentown, PA 18104

FROM: Provider Name: _____

Provider Tax ID#: _____

Provider Address: _____

_____

_____

REGARDING Preferred EAP Client: _____

EAP Client Number: _____

For services rendered to the above noted Preferred EAP out-of-area client, please remit the amount of $ _____ .

Please make check payable to the above noted provider.