Affiliate Reimbursement Form
CHI St. Alexius Health Employee Assistance Program

All referrals terminate on 12.31 of the calendar year, services must be provided in the calendar year

Payable To:

Affiliate Company Name:
Counselor:
Address:
City/State/Zip:

Attn:
email:
Phone: ____/____/____

Referral Information:

EAP Case Manager:
Number of Approved Sessions:

Client Name:

Session Date of Service

☐ Session Date of Appointment ____/____/____ Appt. Time: __________ Session# ( )

OUTCOME – Choose one of the primary options at the time of the last session

☐ EAP-No MH/SA referrals given ☐ MH/SA referral given ☐ Client withdrew from EAP

MH/SA Referral Detail – Choose one primary if referral is given

☐ Resolved in EAP ☐ Medical PCP ☐ Psychologist ☐ Psychiatrist ☐ Other OP Mental Health Provider ☐ Financial Counseling
☐ IP Alcohol Abuse/Chemical Dependency ☐ OP Drug Abuse/Chemical Dependency ☐ IP Mental Health ☐ Legal
☐ Support Group/Self Help ☐ Other

____ _____/_____/_____
Provider Signature Date

Internal Use Only

Received: _____/_____/_____
Fiscal please reimburse the Affiliate Company listed above $______.____ Acct. # 9500-3100
EAP Case Manager/ Director: ____

Payment voucher sent to fiscal: ____/_____/_____ ____________________________________
EAP Staff

This form must be returned within forty five (45) days of the appointment date for reimbursement to occur. Fax: 701.530.7193 or mail: CHI St. Alexius Health Employee Assistance Program, 1310 East main Avenue, PO Box 5510, Bismarck, ND 58506-5510.

CHI St. Alexius Health
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