

**EMPLOYEE RESOURCE SYSTEMS, INC.**  
**BILLING STATEMENT**

**Patient Information**

Patient Name: \_\_\_\_\_ ERS File #: \_\_\_\_\_  
ERS Client Company: \_\_\_\_\_

**EAP Affiliate/Agency Payment Information**

Check Payable to: \_\_\_\_\_ FEIN/SS#: \_\_\_\_\_  
Check Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

**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

Direct questions to: Accounts Payable (866) 377-5550 x 6322 or email to  
accountspayable@ers-eap.com Fax: (312) 269-0309

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

---

ERS Case Manager \_\_\_\_\_ ERS File # \_\_\_\_\_

Date received \_\_\_\_\_ Date paid \_\_\_\_\_ Check # \_\_\_\_\_



Employee Resource Systems, Inc.  
29 E. Madison, Suite 1600  
Chicago, IL 60602-4412

Phone: 312-780-6316  
Fax: 312-269-0309  
www.ers-eap.com  
Revised 01-08-20