# HUMAN DEVELOPMENT COMPANY

## PROVIDER REIMBURSEMENT FORM

**Make Payable To:**

**EAP Group/Provider Name** _____ **Tax I.D.#/SS#** _____

**Billing Address** _____

**City** _____ **State** _____ **Zip** _____

**Phone Number** **Fax Number** **Email Address**

**Activity Codes:**

| | | |
|---|---|---|
| **AS - Assessment** | **BT - Brief Therapy** | **TR - Training** |
| **CID - Debriefing** | **TV - Travel** | **NS - No Show (No Payment)** |

**BILLABLE SERVICES**

**One Client per Billing Sheet**

| Service Date | Client Name | Employee Name | Company Name | Activity Code | Session Number | Session Rate | HDC ONLY |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

By submission of this request for reimbursement, the undersigned (Provider) warrants and represents that (s)he has performed the services identified above on the dates and for the times specified. Provider agrees that timeliness of submission of this form and associated service documentation required by HDC is essential to the performance of services by Affiliate, and so consents to the fee reductions specified below for late submission:

| Number of days received After each service date | Fee Reduction | Net Fee |
|---|---|---|
| Between 61 and 90 | 25% | 75% |
| Between 91 and 180 | 50% | 50% |
| After 181 days | 100% | 0% |

Provider agrees that (s)he shall not seek reimbursement for the above services from any payer other than HDC including the client and/or any insurer. One client per reimbursement form.

_____ _____

**Provider Signature** **Date**

**Return To:** **HDC, Attn: Billing Department**
**1930 Bishop Lane, Suite 603**
**Louisville, KY 40218**
**800-877-8332**
**502-589-5545/FAX**

# HUMAN DEVELOPMENT COMPANY

## SUMMARY FORM

## Session/Training/CID

**Date of Service** _____ **Client/Company Name** _____

**Number of Sessions** _____ **Number of Participants** _____

**Summary:**

_____

_____

_____

_____

_____

_____

_____

**Comments:**

_____

_____

_____

**Recommendations:**

_____

_____

_____

_____ _____

**Provider Signature** **Date**

**Return To:** **HDC, Attn: Billing Department**
**1930 Bishop Lane, Suite 603**
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