Affiliate Provider Reimbursment Claim Form

Provider Name: ______________	Date of Claim: ______________	(For Internal Use Only) Invoice #: ______________

Provder Mailing Address: ______________________________
Number and Street / City / Zip

Provider Social Security # or Tax I.D. #: ______________________________

Pay Rate Per Session: $ ______________________________

Authorized Clinical Activity
Date(s) of Session(s)

*Life*Solutions Client Case #	Client's DOB	Date	Date	Date	Date	Date	Date	Total # Sessions	Total $ Due
Totals:									

______________________________ ______________
Provider Signature Date

Claim approved by: ______________________________ ______________
*Life*Solutions Care Manager Date

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