



AFFILIATE PROVIDER REIMBURSEMENT CLAIM FORM

Provider Name	Date of Claim	(For Internal Use Only) Invoice #
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Provider Mailing Address (No. & Street, City, State, Zip)

Provider Social Security # or Tax I.D. # _____

Pay Rate: Per Session \$ _____

**AUTHORIZED CLINICAL ACTIVITY
DATE(S) OF SESSION(S)**

<i>LifeSolutions</i> Client Case #	Client's DOB	Date	Date	Date	Date	Date	Date	Total # Sessions	Total \$ Due
Totals:									

_____	_____
Provider Signature	Date
Claim Approved by: _____	_____
<i>LifeSolutions</i> Care Manager	Date