

## INSTRUCTIONS COMPLETING THE EAP CASE ACTIVITY AND BILLING FORM

**Please note:** To ensure timely processing of your EAP billing please provide all information as requested. Case Closing information is not required for Interim billing. *Please print neatly. Incomplete or illegible EAP Case Activity and Billing Forms may be returned without payment.*

**BILLING TYPE:** Indicate status of billing by checking appropriate box in upper right-hand corner (Interim, Final or Re-Open).

**PAYER NAME:** Indicate name of company/division, location or department through which EAP benefits are available.

**EAP PARTICIPANT DEMOGRAPHIC INFORMATION:** Information about the participant receiving services and the employee (subscriber) of the EAP benefit.

Information requested	How to complete this section
Last Name(s), First, MI	Indicate last name, first name, and middle initial of the identified individual or recipient of services
Participant Gender	Indicate gender of participant by checking appropriate box
Correspondence Address	Provide full correspondence address of participant, including City, State and ZIP
Participant DOB	Indicate participant's date of birth
Home Phone	Indicate participant's home telephone number
Employee Name (if not participant)	Indicate last and first name of the employee who is the subscriber of the EAP benefit, if not the participant
Employee Social Security Number	Provide the Social Security Number of the employee who is the subscriber of the EAP benefit
Employee Hire Date	Provide hire date of the employee who is the subscriber of the EAP benefit
Statement of Understanding Signed	Indicate by checking box whether participant reviewed and signed Statement of Understanding
Release of Information Signed	Indicate by checking box whether participant signed Release of Information form (if applicable)
Participant Category	Indicate whether participant is the employee (Self), spouse, dependent, etc. by checking appropriate box
Learned About EAP	Indicate the method by which the participant learned about the EAP by checking appropriate box
Method of Initial Contact	Indicate the method in which the participant initially contacted the EAP
Relationship Status	Indicate relationship status of participant by checking appropriate box
Referral Source	Indicate source of referral to the EAP by checking appropriate box
Ethnicity	Indicate ethnicity of participant by checking appropriate box

**BILLING INFORMATION:** Information necessary to reimburse provider for services.

Information requested	How to complete this section
Date(s) of Service	Enter the date each session was provided (month/day/year)
Total Sessions Billed	Indicate total number of sessions for this billing
Number EAP Sessions Used at Case Closing	Indicate total number of sessions used (only required at Case Closing)
EAP Clinician Name & Credentials	Indicate name and credentials of the individual providing the service
EAP Clinician Signature	Include signature of clinician
Date	Indicate date form signed
EAP Clinician Billing Address	Indicate full address (with PO box number, if applicable) of the individual or group to be reimbursed
Phone	Indicate telephone number of clinician providing services or an office manager to whom questions can be directed
SSN or Tax ID	Indicate SSN or Tax ID of clinician or group/organization
NPI Number	Indicate clinician's National Provider Identifier number

**EMPLOYMENT DATA:** To be completed only if the employee is the participant.

Information requested	How to complete this section
Employment Status	Indicate employee's current employment status by checking appropriate box
Job Title Category	Indicate category of employee's job by checking appropriate box
Job Dysfunction	Indicate whether employee is experiencing any job dysfunction, and to what extent, by checking appropriate box
Job Problem	If employee is experiencing job dysfunction, indicate nature of the job problem by checking appropriate box

**PRESENTING VS. ASSESSED PROBLEM:** Information regarding the problem for which the participant is seeking assistance.

Information requested	How to complete this section
Presenting Problem	Select one Presenting Problem, as presented by the participant, from one of the four categories, checking the box next to the problem and in the "P" column
Assessed Problem	Select one Assessed Problem, as assessed by the clinician, from one of the four categories, checking the box next to the problem and in the "A" column

**RISK ASSESSMENT:** Information regarding participant's risk to self or others.

Information requested	How to complete this section
Member's risk to self	Indicate level of risk to self by checking appropriate box both for case opening and case closing, using scale provided
Member's risk to others	Indicate level of risk to others by checking appropriate box both for case opening and case closing, using scale provided

**FUNCTIONAL ASSESSMENT:** Indicate participant's level of impairment for each item both at case opening (O) and at case closing (C) by checking the appropriate boxes. General definitions for each rating are indicated below.

Rating	Definition
0	No evidence of impairment
1	Mild impairment (occasional impairment or difficulties, but no interference with normal daily activities)
2	Moderate impairment (frequent disruption in daily activities, requires periodic or continuous assistance with some tasks)
3	Severe impairment (severe symptoms, potential risk for harm to self/others, severe distress and/or disruption in daily activities)

**GOALS:** List up to three service goals, and indicate status of goals by checking appropriate box.

**EAP/Psychiatric Treatment History Assessed:** Check appropriate box and provide brief statement regarding relevant history.

**Substance Abuse Treatment History Assessed:** Check appropriate box and provide brief statement regarding relevant history.

**Strengths, Skills, Aptitudes & Interests Assessed:** Check appropriate box and provide brief statement summarizing assessment.

**Supports Assessed:** Check appropriate box and provide brief statement summarizing assessment.

**Military History Assessed:** Check appropriate box and provide brief summary of relevant history.

**CASE CLOSING:** Case disposition information – *to be completed only at case closing.*

Information requested	How to complete this section
Problem Status at Case Closing	Indicate status of participant's presenting problem at case closing by checking appropriate box
Case Disposition	Indicate Case Disposition by checking appropriate box
Referral Type	Provide information regarding any referrals made by checking appropriate box

***Thank you - we value and appreciate your continued support as a provider of EAP services for ValueOptions.***