EFR EMPLOYEE & FAMILY RESOURCES

EAP Billing and Closing

AN ASSESMENT MUST BE SUBMITTED FOR REIMBURSMENT AS WELL AS A CURRENT COPY OF LICENSE AND LIABILITY

Provider agency:_____

Clinician name:_____ **Authorization #:**_____

Please mark only 3 assessed issues below. Primary (mark as 1), secondary (mark as 2), and tertiary (mark as 3).

Addictions - Concern for other	Concerned Person/Mental Health	Health/Wellness	School Academic Performance
Alcohol	Depression	Housing/Basic Needs	School Attendance
Alcohol and Other Drug	Drugs	Illiteracy	Stress/Emotional Adjustment
Anger	Eating Disorder	Language Barrier	Tobacco Abuse/Addiction
Anxiety	Elder Care	Legal	Tobacco/Nicotine Cessation
Behavioral/Child or Adolescent	Family	Marital/Couple	Trauma
Bullying/Perpetrator	Family/Partner Violence	Medical/Physical	Work Attendance/Timeleness
Bullying/Victim	Finanical	Mental Health - Other	Work Performance/Productivity
Career/Vocational	Gambling	Parenting	Work Relationships
Child Care	Grief/Loss	Peer/Friendships	Work-Related Stress

Date of Session	**Name & DOB of all clients in attendance**	**Modality of Session (In Person or Telehealth)**	**Session length**

CLOSING INFORMATION (please complete AFTER final session)

Case Disposition (circle one)	**Referral** (circle one)	**Referral Type**	**Referral Payment Type (circle one)**
Improved / Resolved Requires referral Outcome unknown	Yes No	(See codes below, use all that apply)	No Fee Sliding Fee Insurance Private Pay

01 – Alc/Drug Medically Managed Inpatient	06 – Alcohol/Drug Self-help Group	11 – Social worker/Therapist Outpatient	16 – Financial Services
02 – Alcohol/Drug Residential Treatment	07 – Mental Health Inpatient	12 – Self-help Group (not Alcohol/Drug)	17 – Basic needs (food, shelter)
03 – Alcohol/Drug Intensive Outpatient	08 – Mental Health Day Treatment	13 – Medical Services	18 – Other (specify)
04 – Alcohol/Drug Continuing Care	09 – Psychiatrist Outpatient	14 – Vocational/Education	
05 – Alcohol/Drug Education	10 – Psychologist Outpatient	15 – Legal Services	

Self-referral: To ensure clients referral options are not influenced by conflict of interest, all clients must be offered at least two resources in addition to the self-referral. Were other options to the self-referral offered? ____Yes ____No If no, provide explanation.

CLOSING SUMMARY (assessment outcome and plan for moving forward)

In accordance with the Provider Contract or Single Case Agreement, I understand that the client is not to be billed, nor is any EAP company, their insurer, or third party payor for any portion of the services authorized by Employee & Family Resources. **Completed paperwork is due within 90 days of each date of service.**

Clinician Signature: _____ **Date:** _____