6 EAP WORKS

CLIENT TRACKING, CASE CLOSING, AND BILLING SUMMARY

Please fax or e-mail this form to EAP Works upon completion of all sessions for prompt payment.
Ph: 1-844-361-4348, Fax: 844-996-1303 or email: info@eapworklife.com

CLIENT INFORMATION

Name:____Date of birth: __________ Case #:________

Chief complaint:____

IMPORTANT: Please submit your billing within 30 days of the final session.

SESSION INFORMATION

Number approved:__________ Modality: ☐ Face to face ☐ Telephone ☐ Video

DATE	PRESENTING ISSUE	NUMBER OF PEOPLE SERVED

CASE CLOSING INFORMATION: Is this EAP case closed? Yes ___, No ___

Will client continue counseling using insurance? Yes ___, No ___ (answer required for payment)

Name of patient's insurance provider:____
Referrals (Must be in client's network; check all that apply, include self-referrals):
___ Psychiatric Referral for medication evaluation, ___ Outpatient Mental Health,
___ Inpatient Mental Health, ___ Outpatient Chemical Dependency, ___ Inpatient Chemical Dependency
Support Groups: AA ___, NA ___, CA ___, Al-Anon ___, OA ___, Other ______________________________

Name of professional(s) providing services beyond the EAP including self-referrals: ____________________________

Closed case summary (include medications):____

____

Provider Name (Please Print) :____

Provider Signature:____ Date:__________________________

Thank you for providing services to our EAP Works clients!