AUTHORIZATION OF SERVICE

*First*CALL EAP
101 South Bryn Mawr Avenue
Suite 260
Bryn Mawr, PA 19010

FAX: 610.526.4426

Authorization ID: ________

Authorized Provider Information

Name: ____
Address: ____
____
____

Phone Type:	Phone:
________	____________________
________	____________________

Client Information on File **Case #:**

Name: ____
Address: ____
____
____

Phone Type:	Phone:	Msg. OK?
________	____________	________
________	____________	________
________	____________	________

Organization: ____
Primary Presenting Problem: ______________________________
Client Type: ____
Gender: ____
Date of Birth: ____

Special Instructions:

Sessions Authorized: **Start Date:** **End Date:**

SUMMARY OF CONTACTS:
(List only completed sessions; do not list no-shows or cancellations. Circle the appropriate Contact Type and Service Type codes.)

DATE OF SERVICE	TIME (am/pm)	LENGTH OF CONTACT	CONTACT TYPE*	SERVICE TYPE**
______/______/__________	______:______ AM / PM	______ HRS ______ MIN	T / P	CA / CT
______/______/__________	______:______ AM / PM	______ HRS ______ MIN	T / P	CA / CT
______/______/__________	______:______ AM / PM	______ HRS ______ MIN	T / P	CA / CT
______/______/__________	______:______ AM / PM	______ HRS ______ MIN	T / P	CA / CT
______/______/__________	______:______ AM / PM	______ HRS ______ MIN	T / P	CA / CT
______/______/__________	______:______ AM / PM	______ HRS ______ MIN	T / P	CA / CT
______/______/__________	______:______ AM / PM	______ HRS ______ MIN	T / P	CA / CT
______/______/__________	______:______ AM / PM	______ HRS ______ MIN	T / P	CA / CT

*** T = Telephone Session/ P = Face-to-Face Session** **** CA = Clinical Assessment / CT = Short-Term Counseling**

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ASSESSED PROBLEM(S):
(Select no more than one in each column)

Primary	***Secondary***
☐ Alcohol	☐ No secondary problem
☐ Drugs	☐ Alcohol
☐ Emotional/Mental Health Concern	☐ Drugs
☐ Financial	☐ Emotional/Mental Health Concern
☐ Legal	☐ Financial
☐ Medical	☐ Legal
☐ Relational	☐ Medical
☐ Occupational	☐ Relational
☐ Substance Abuse in Family	☐ Occupational
☐ Dependent Care Needs	☐ Substance Abuse in Family
☐ Other (specify):	☐ Dependent Care Needs
	☐ Other (specify):

CLOSING SUMMARY: ***Please note: By submitting this form, you have closed this authorization. You will not be able to submit another request for payment for any remaining sessions under this authorization.***

Closing Status:
RESOLUTION:*(Select one code only)*

☐ Referral Accepted ⟶

☐ Referral Declined

☐ No Referral Necessary (EAP Only)

☐ Client Discontinued Prematurely

Specify Closing Date: ____ / ____ / ________

Referral Destinations: *
(Complete only if status is "referral accepted"; check all that apply)

☐ Inpatient Psychiatric, Acute
☐ Inpatient, Chemical Dependency Detox
☐ Inpatient, Partial Hospitalization
☐ Inpatient, Chemical Dependency Rehabilitation
☐ Outpatient, Chemical Dependency Detox
☐ Outpatient, Intensive
☐ Outpatient, Standard
☐ HMO/MCO for Evaluation/Treatment
☐ Medical Provider/Facility
☐ Social/Legal/Financial Services
☐ Other:____

Signature/Degree of Evaluator:____ Date: ________________________

Please be certain that all sections of the Authorization/Case summary are complete and that the client has read and signed the enclosed program Statement.

Sign, date and mail or fax this form and the Program Statement to the address above.