EXHIBIT A

9239 W Center Road, Suite 201
Omaha, NE 68124-1900
402.354.8000/800.801.4182
Fax: 402.354.8046
www.BestCareEAP.org

02/20/2020

Authorization Of Service

File #:
Authorization #:

Authorized Provider Information

Provider:

Phone Numbers

Office:

Office Location:

Fax:
Other:

Payment Address:

FEIN/SIN #:
Email:

Please indicate any changes to your practice above and include an email address for future communications.

Client Authorization Information

Name:
Address:

Phone Numbers	Permission to Call	Permission to Leave Message
Home:	■	■
Work:	■	■
Cell:	■	■

Date Of Birth:

Last 4 SS #:

Organization:

Sessions: @ for
Start Date:
End Date:

Any additional services must be authorizaed by Best Care EAP. Client is responsible for payment of unauthorized services.

Best Care Case Manager:

Special Instructions:

Session #	Session Date	Appt. Change (late notice)*	No Show*	Duration (hrs)	Attendee(s)
		☐ *	☐ *		
		☐ *	☐ *		
		☐ *	☐ *		
		☐ *	☐ *		
		☐ *	☐ *		
		☐ *	☐ *		

*Appointment changes with less than 24 hour notice or no shows will be deducted from the number of authorized sessions.

REIMBURSEMENT REQUIREMENTS: Within 45 days of the end date on the Authorization, submit Best Care EAP's Statement of Understanding, Substance Use Assessment (when applicable) and two-page Authorization of Service completed/signed. Please fax or mail your reimbursement paperwork to Attn: Network Services at the fax number or address listed above or email to networkservices@bestcareeap.org.

SAMPLE

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File #:
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Assessed Problem(s): 1 = Primary 2 = Secondary 3 = Tertiary

______Addiction/Abuse - Other ______Anger ______Anxiety ______Child/Adolescent
______Depression ______Domestic Violence ______Emotional/Mental Health ______Family
______Financial ______Grief/Loss/Bereavement ______Job/Career ______Legal
______Life Transitions ______Physical Health ______Marital/Relationship ______Stress
______Substance Abuse/Addiction ______Trauma ______Wellness

Clinical Impressions: ______________________________

____

____

Counseling/Treatment Plan: ______________________________

____

____

Clinically Necessary Referral Type: ______No Referral Beyond EAP

______Agency ______APRN ______Education/Training
______Financial ______Inpatient ______Legal
______MD ______Psychiatrist ______Psychologist
______SAP ______Self-Help ______Substance Use Disorder
______Therapy ______Therapy Groups

Additional Recommendations: ______________________________

____

____

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SAMPLE