BEST CARE
EMPLOYEE ASSISTANCE PROGRAM

9239 W Center Road, Suite 201
Omaha, NE 68124-1900
402.354-8000 / 800.801.4182
Fax: 402-354-8046
www.BestCareEAP.org

Date

Authorization Of Service

File #:####
Authorization #:####

Authorized Provider Information

Provider: ABC Agency

Office Location: 1234 Any Street
Hometown, NE 68888

Payment Address: 1234 Any Street
Hometown, NE 68888

Phone Numbers
Office: (555) 123-4567
Fax: (555) 123-4567
Other:

FEIN/SIN #:
Email:

Please indicate any changes to your practice above.

Client Authorization Information

Name: Public, John Q
Address: 5678 Any Street
Hometown, NE 68888

Phone Numbers		Permission to Call	Permission to Leave Message
Home:		☐	☐
Work:		☐	☐
Cell:	(###) ###-####	☑	☑

Date Of Birth: 08/15/1965
Last 4 SS #: 7890
Organization: Widgets R Us

Sessions: 1 @ $130.00 for Alcohol/Drug Assessment
Start Date: 07/19/2018
End Date: 12/31/2018

The client will need to contact Best Care EAP for authorization for any additional EAP services. It is the responsibility of the client to pay for any services utilized outside of authorized EAP services.

Best Care Case Manager: Coleman, Terry

Special Instructions: Client has been referred for an alcohol/drug assessment following a positive drug screen at work. Please call me at 800-801-4182 with the date and time of the assessment. Please ensure the client signs the proper release forms. Also, please consult with me, or another Best Care EAP counselor, to determine any treatment recommendations.

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.

In order to be reimbursed, you must submit Best Care EAP's Statement of Understanding, Alcohol/Drug Assessment (when applicable) and two-page Authorization of Service form within 90 days of the last date of service. These forms can be accessed in the forms section of our web site at www.bestcareeap.org. Feel free to duplicate the forms for use with future Best Care EAP referrals. Please fax or mail your reimbursement paperwork to the attention of our Business Office Manager at the fax number or address listed above or email to eap@bestcareeap.org.

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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: _____