EAP TRACKING AND CASE CLOSURE FORM

For EAP Billing/Payment – All Information must be provided to avoid form being returned without reimbursement

Client Name _____**Pt ID# or DOB**:_____
(located on authorization letter)

Employer _____ Provider Name _____
Group Practice Name _____

Names of other persons attending counseling:

_____

CASE DISPOSITION: _____ Open and Active _____ Closed (see reason below)

DATES OF SERVICE

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10. _____

DSM V DIAGNOSES

Primary Diagnoses _____ Closing Diagnoses _____

Reason EAP services have ended (check the one that applies):

_____ Client (s) issue(s) resolved conclusively within EAP services

_____ Client (s) required outside referral(s) beyond EAP services – Type of referral?

_____ Client (s) do not want or need additional services at this time (circle one)

_____ Client(s) terminated EAP services before completion of assessment/treatment

DATE

CLINICIAN SIGNATURE & CREDENTIALS **CLINICIAN'S NAME (Print)**

RETURN TO: eni, 1040 Vestal Parkway East, Vestal, NY 13850 or FAX: 607-341-4623 or 607-754-8762