EAP TRACKING AND CASE CLOSURE FORM

For EAP Billing/Payment – All information for dates of service must be provided within 90 days of each treatment to avoid claim denial. Claims submitted for dates of service beyond the 90 days timely filing will be denied and subject to a written appeal.

Client Name _____ Pt ID#_____

Employer _____

Name of other persons attending counseling:

_____

Provider Name _____

Practice Name _____

Practice Mailing Address _____

City_____ State _____ Zip Code _____

Email Address _____

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

CLINICIAN SIGNATURE & CREDENTIALS	**CLINICIANS NAME (Print)**	**DATE SUBMITTED**

Email Form To: Claims@eniweb.com