

INTEGRATED BEHAVIORAL HEALTH

WORKLIFEMATTERS EAP CASE SUMMARY

Please complete & return to IBH with billing.
(Claims will not be processed until Case Summary is received.)

GENERAL INTAKE

EAP Counselor:		Date Case Opened:	
Phone:	Fax:	EAP Group Name:	
Address:			
City:		State:	Zip:
Intake Service Level: (Check One Only) <input type="checkbox"/> Crisis <input type="checkbox"/> Urgent <input type="checkbox"/> Priority <input type="checkbox"/> Routine <input type="checkbox"/> Other			
Patient Name: _____			
Insured's Name (if Different from Patient): _____		Insured's SS#: _____	
Account (Insured's Employer or Union): _____			
Referred to EAP By: (Check One Only) <input type="checkbox"/> Co-Worker <input type="checkbox"/> Union <input type="checkbox"/> Human Resources <input type="checkbox"/> Employer/Supervisor <input type="checkbox"/> Medical <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Family <input type="checkbox"/> Self-Referred* <input type="checkbox"/> Other			
*If Self-Referred , List How Patient Knew about EAP: (Check One Only) <u>Self-Orientation:</u> <u>EAP Literature:</u> <u>EAP Services:</u> <input type="checkbox"/> New Employee Orientation <input type="checkbox"/> Employee Manual/Benefits Literature <input type="checkbox"/> Workshop/Seminar <input type="checkbox"/> Brochure <input type="checkbox"/> Posters/Flyers <input type="checkbox"/> Management, Union, or Employee Training			

CLIENT DEMOGRAPHICS

Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:	Length of Service with Employer: <input type="checkbox"/> < 1yr <input type="checkbox"/> 1-5 yrs <input type="checkbox"/> 6-10 yrs <input type="checkbox"/> 11-15 yrs <input type="checkbox"/> 16-20 yrs <input type="checkbox"/> > 20 yrs
Client Relationship to Insured (Employee/Union Member): (Check One Only) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married
Age: <input type="checkbox"/> 0-10 <input type="checkbox"/> 10-20 <input type="checkbox"/> 20-30 <input type="checkbox"/> 30-40 <input type="checkbox"/> 40-50 <input type="checkbox"/> 50-60 <input type="checkbox"/> Over 60		

JOB PERFORMANCE/ATTENDANCE PROBLEMS

(Applies only if Patient is Same as Insured)

Performance or Attendance Problems in the Last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, Primary Reason for Performance/Attendance Problems (Check one only):			
<input type="checkbox"/> Work Problem/Duties	<input type="checkbox"/> Suspension	<input type="checkbox"/> Depression	<input type="checkbox"/> Medical Problem
<input type="checkbox"/> Work Problem/Peer	<input type="checkbox"/> Drug/Alcohol Problem	<input type="checkbox"/> Sleep Disorder Problem	<input type="checkbox"/> Worker's Compensation
<input type="checkbox"/> Work Problem/Supervisor	<input type="checkbox"/> Dependent Care Problem	<input type="checkbox"/> Other Mental Health Problem	<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Work Problem/Other			<input type="checkbox"/> Other

PROBLEM ASSESSMENT

PRIMARY PROBLEM (Check one only):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Violent Thoughts | <input type="checkbox"/> Friend Relational | <input type="checkbox"/> School |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Vocational |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Polysubstance Abuse | <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Work Problem / Duties |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Family Drug/Alcohol Problem | <input type="checkbox"/> Child Care | <input type="checkbox"/> Work Problem / Peer |
| <input type="checkbox"/> Sexual Problem | <input type="checkbox"/> Gambling Addiction | <input type="checkbox"/> Dependent Adult Care | <input type="checkbox"/> Work Problem / Supervisor |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Marital/Life Partner Relational | <input type="checkbox"/> Elder Care | <input type="checkbox"/> Work Problem / Drug Test |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Significant Other Relational | <input type="checkbox"/> Financial | <input type="checkbox"/> Work Problem / Attendance |
| <input type="checkbox"/> High Risk Behavior | <input type="checkbox"/> Child Relational | <input type="checkbox"/> Legal | <input type="checkbox"/> Work Problem / Other |
| <input type="checkbox"/> Violent Behavior | <input type="checkbox"/> Parent Relational | <input type="checkbox"/> Housing | <input type="checkbox"/> Medical Complications |

SECONDARY PROBLEMS (May be more than one per Client):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Violent Thoughts | <input type="checkbox"/> Friend Relational | <input type="checkbox"/> School |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Vocational |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Polysubstance Abuse | <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Work Problem / Duties |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Family Drug/Alcohol Problem | <input type="checkbox"/> Child Care | <input type="checkbox"/> Work Problem / Peer |
| <input type="checkbox"/> Sexual Problem | <input type="checkbox"/> Gambling Addiction | <input type="checkbox"/> Dependent Adult Care | <input type="checkbox"/> Work Problem / Supervisor |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Marital/Life Partner Relational | <input type="checkbox"/> Elder Care | <input type="checkbox"/> Work Problem / Drug Test |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Significant Other Relational | <input type="checkbox"/> Financial | <input type="checkbox"/> Work Problem / Attendance |
| <input type="checkbox"/> High Risk Behavior | <input type="checkbox"/> Child Relational | <input type="checkbox"/> Legal | <input type="checkbox"/> Work Problem / Other |
| <input type="checkbox"/> Violent Behavior | <input type="checkbox"/> Parent Relational | <input type="checkbox"/> Housing | <input type="checkbox"/> Medical Complications |

REFERRALS

REFERRAL GIVEN TO: (Check All That Apply)

- | | | | |
|---|--|---|---|
| Behavioral Health Services | | <input type="checkbox"/> Continued EAP Services | |
| <u>Provider Type:</u> | <u>Psychiatric Programs:</u> | <u>Medical Treatment:</u> | <u>Employer/Union Resources:</u> |
| <input type="checkbox"/> LPC/MFCC/LCSW | <input type="checkbox"/> Psych Inpatient | <input type="checkbox"/> Inpatient Medical Program | <input type="checkbox"/> Human Resources |
| <input type="checkbox"/> PhD | <input type="checkbox"/> Psych Residential | <input type="checkbox"/> Medical/Personal Physician | <input type="checkbox"/> Supervisor |
| <input type="checkbox"/> MD | <input type="checkbox"/> Psych 6-8 Hr SOP | | <input type="checkbox"/> Employer/Union Rep |
| <input type="checkbox"/> Other | <input type="checkbox"/> Psych 3-4 Hr IOP | <u>Community Resources:</u> | <input type="checkbox"/> Financial |
| <u>Outpatient Behavioral Treatment:</u> | <u>Chemical Dependency Programs:</u> | <input type="checkbox"/> Child Care | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Group Therapy | <input type="checkbox"/> CD Detox | <input type="checkbox"/> Elder Care | <input type="checkbox"/> Social Agency |
| <input type="checkbox"/> Marital Therapy | <input type="checkbox"/> CD Inpatient | <input type="checkbox"/> Career Counseling | <input type="checkbox"/> AA or Other 12-Step |
| <input type="checkbox"/> Individual Therapy | <input type="checkbox"/> CD Residential | <input type="checkbox"/> Academic Counseling | <input type="checkbox"/> Grief Group |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> CD 8-Hr SOP | <input type="checkbox"/> Stress Management | <input type="checkbox"/> Parent Education Group |
| | <input type="checkbox"/> CD 4-Hr IOP | <input type="checkbox"/> Legal | <input type="checkbox"/> Other Support Group |

If **Behavioral Health** Treatment Referrals were made, were the Providers or Facilities within the Insured's Benefit Plan: Yes No

CASE CLOSURE SUMMARIES

- | | | |
|--|-------------------|-------------------|
| Number of EAP Sessions: | Date Case Opened: | Date Case Closed: |
| Case Closed Due To: | | |
| <input type="checkbox"/> Resolved <input type="checkbox"/> Declined Help <input type="checkbox"/> Suspended <input type="checkbox"/> Terminated <input type="checkbox"/> Laid Off <input type="checkbox"/> Quit Job <input type="checkbox"/> Retired <input type="checkbox"/> Deceased | | |

ASSESSMENT/REFERRAL OUTCOMES

- Check One of the Following:
- | | |
|---|---|
| <input type="checkbox"/> Improved/Resolved problem through EAP only | <input type="checkbox"/> Accepted referral & completed referral |
| <input type="checkbox"/> Accepted referral but client failed to complete referral | <input type="checkbox"/> Refused EAP assistance |
| <input type="checkbox"/> Other (left employment; unable to contact) | |

TREATMENT/FOLLOW-UP OUTCOMES

- Check One of the Following:
- | | |
|--|---|
| <input type="checkbox"/> Completed major EAP recommendations | <input type="checkbox"/> Completed some EAP recommendations |
| <input type="checkbox"/> Refused EAP assistance | <input type="checkbox"/> Other (left employment; unable to contact) |

INTEGRATED BEHAVIORAL HEALTH

PO Box 30018, Laguna Niguel, CA, 92607-0018 • (800) 386-7055 • Fax (714) 556-5430

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize
(please print or type client name)

EAP Provider Name: _____

Address: _____

Telephone: (_____) _____

to disclose records and information obtained in the course of EAP Services to Integrated Behavioral Health and its authorized employees.

I, _____, hereby authorize Integrated Behavioral Health
(Client Name)
and its authorized employees to provide the above named provider with information regarding my EAP benefits, and to disclose and discuss all information needed to determine the necessary and appropriate services.

I understand that I can limit my disclosure to specific types of information and have noted disclosure limitations as follows (Check and initial #1 or #2):

- | | |
|--|--|
| 1. <input type="checkbox"/> No disclosure limitations | 1. _____
<i>(Client's Initials)</i> |
| 2. <input type="checkbox"/> Disclosure limited to the following types of information | 2. _____ |

I understand that I can revoke this consent at any time, except to the extent that action has been taken in reliance of this consent prior to my revocation. I understand that this authorization will expire two years after the date of my signature, or, if not earlier revoked, it shall terminate on:

(Event, Date, or Condition)

I also understand that I have a right to a copy of this authorization.

Client Name (Please Print): _____

(Signature of Client, Parent, Guardian or Authorized Representative of Client) *Date*

(If signed by other than client, indicate legally responsible relationship)

Subscriber SS #: _____

**Return to: Integrated Behavioral Health
WorkLifeMatters EAP Services
P. O. Box 30018
Laguna Niguel, CA 92607-0018**

HIPAA NOTICE:

THIS INFORMATION HAS BEEN DISCLOSED FROM CONFIDENTIAL RECORDS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT ANY FURTHER DISCLOSURE OF THIS CONFIDENTIAL INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

Integrated Behavioral Health



EAP Claim Form

EMPLOYEE INFORMATION (If any information is missing, please have the patient complete)				
Date	Name		Soc. Sec. Number	
Mailing Address		City	State	Zip Code
Home Phone	Employer / Company			
MEMBER INFORMATION				
Name		Birth Date	Gender	Relationship to Employee
CLAIM INFORMATION (To be completed by Provider)				
Member ID Number		Authorization Number		
Dates of Service	CPT-4 Code	Length of Session	Amount Charged	
PROVIDER INFORMATION				
Name			Phone	
Address		City	State	Zip Code
Tax ID Number	NPI Number	License Number		
Signature _____			Date _____	
<i>In order to process your claim, please include a completed EAP Case Summary.</i>				

Mail claim to:
 Integrated Behavioral Health
 Attn: Claims
 P.O. Box 30018
 Laguna Niguel, CA 92607-0018

**For questions, problems or
 for prior authorization, call
 IBH at:**
 1-800-395-1616

OR

Fax claim to:
 (714) 556-5430