

Billing Forms Options / Instructions:

1. EAP Client Record Instructions

Page 1 - Intake Data Sheet: Complete Employee's Section of the form. Complete the Client Section of the form. Please make sure to enter the Client Name if this is not the employee.

Statement of Understanding: Please review the Statement of Understanding with the client on the first visit. Have patient sign the Statement of Understanding. NOTE: In order for you to be paid, an original client signature must be on the form! *All clients should be offered a copy of the Statement of Understanding.*

Page 2 - Contact History Page: Initial Visit Assessment: Please fill in this portion on the initial visit with the client. You will also need to fill out the Counselor Assessment, Goals and Plan for the first visit. Enter Dates of Service (from 3-8 sessions - see faxed authorization).
Final Summary: Please fill out the last date of service.

Submitting paperwork: Please submit billing paperwork following the last date of service. *All billing paperwork must be received within 90 days following the last date of service to be considered for payment.*

→ Please fax your paperwork to 610-993-0172 or mail it to: Carebridge Corporation, 40 Lloyd Avenue, Suite 107, Malvern, PA 19355.

--OR--

2. New Online EAP Intake Record Submission Form for Providers:

Providers are invited to go to the new website where you can fill out the form on-line and submit it directly. A copy will be returned to you for your files.

<http://www.carebridge.com/providers/eapsubmissionform.htm>

Our new online form will reduce your paperwork and expedite the resolution of your Carebridge EAP cases.

If you have any questions please feel free to contact the EAP Department at 800-437-0911

**Carebridge
EAP Case Record**

**CONFIDENTIAL
INTAKE RECORD**

Instructions: At the first appointment, have client (guardian) read and sign the Statement of Understanding.
Statement of Understanding. Mail of fax completed case record to Carebridge.

EMPLOYEE

Employee Name (Last, First)	Company Name
-----------------------------	--------------

Company's City/State: _____

Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employee Birthdate / /	Employee's Job Title:
--	---------------------------------	-----------------------

CLIENT

Client Name (If not employee)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
-------------------------------	--	-------------------------------

Client is Employee Employee & Dependent Retiree
 Spouse Child Other

Phone Home Numbers ()	Work ()	Case Open Date / /
---------------------------------	-------------------	-----------------------------------

Statement of Understanding

1. **Extent of EAP Services** The EAP offers assessment, consultation, and short-term counseling for your personal concerns. Often short-term counseling is completed within the allotted EAP sessions. However, the number of required sessions is determined by your counselor. If after the initial assessment, or at any point during the EAP service, the EAP counselor determines that long-term counseling is necessary, you will be referred out of the EAP. Your remaining unused EAP visits will be "banked" for future visits in the next 12 months if needed. You will have to call Carebridge to re-authorize these sessions.
2. **Cost** There are no charges to you or your family for using the EAP services. There may be charges, however, should you be referred to, and choose to utilize, the services of other professional resources. If an outside referral is chosen, every effort will be made to find the best resource at the lowest cost to you. Certain costs may be partially offset by your Medical Benefit Plan. Contact your carrier for plan benefits and exclusions.
3. **Confidentiality** All records kept by the EAP will be treated confidentially. No information can be released outside the EAP without your written consent, unless required by law. Various laws require that the EAP staff assume the responsibility for reporting to appropriate parties instances when a person is a danger to themselves, to others, or when child abuse/neglect is involved. To keep this program confidential, your employer has contracted with Carebridge, an independent outside benefit firm, to administer the EAP.
4. **Supervisor Referrals** If a supervisor requires that you contact the EAP (for instance, because of a performance problem), the supervisor will not be informed of any details of your counseling without your signed consent.
5. **Complaints** If you have a complaint concerning any person associated with the EAP service, the quality of service provided, or any other aspect of the EAP, you may register the complaint with Carebridge by calling 800-437-0911.
6. **Satisfaction Survey** As a part of quality assurance, I further authorize Carebridge to contact me to survey my satisfaction with the services I received.
7. **Signature** I have read this statement and may receive a copy.

Client/Guardian Signature _____ Date _____

EAP Counselor Signature _____ Date _____

Please be aware that Carebridge EAP is NOT an insurance provider. We do NOT accept HCFA billing forms. All completed EAP Case Records must be submitted within 90 days of the last face/face session in order to be considered for payment.

Client Name		
Company Name	Dates of	Mailing Address: Carebridge Corporation 40 Lloyd Ave, Suite 107 Malvern, PA 19355 Fax Number: 610-993-0172 Phone Number: 800-437-0911
Counselor Name	Service	
Address	/ /	
	/ /	
	/ /	
Phone	/ /	
Remit To	/ /	
	/ /	
	/ /	
	/ /	

Initial Visit Assessment
Presenting Problem (Client)

Counselor Assessment

Goals

Plan

Final Summary (last f/f session)