

USE OF IEAP FORMS

The following pages contain examples of the IEAP forms along with the purpose of the forms. Providers who fail to give patients the required forms will be denied payment of EAP sessions. You should have received original copies of IEAP's required forms along with your contract. IEAP asks providers to keep the originals in a file and make copies as needed for IEAP patients. If at any time you find yourself needing new originals, please contact the Provider Relations department or you can obtain them from our website at www.ieap.com.

A. PATIENT RIGHTS AND RESPONSIBILITIES

The patient will receive and read this form at the time of their initial assessment. This informs the patient of his/her rights with regards to confidentiality, refusal of treatment, and of his/her responsibility to cancel scheduled appointments at least 24 hours in advance.

B. EXPLANATION OF EAP BENEFITS AND RELEASE OF INFORMATION

The patient will receive and read this form at the time of their initial assessment. This form explains to the patient how his/her EAP sessions are used and authorized. This form ensures IEAP that the patient has received the *Explanation Of EAP Benefits and Release of Information form*, which informs the patient that IEAP holds him or her responsible for contacting IEAP for authorization of care, and that the Provider can hold the patient responsible for payment if he or she chooses not to contact IEAP. It also allows the provider to release results of the assessment for purposes of directing care and allows IEAP to pay for the authorized EAP sessions. A patient who receives this form and chooses to continue treatment without notifying IEAP of his/her choice may be financially responsible for that treatment. A provider who fails to give this form to an IEAP patient and continues treating patient without IEAP being contacted will not hold the patient responsible for that treatment. Please note that the patient must sign that they have received this form. (*This form is not required on EAP only accounts*).

C. CLINICAL FEEDBACK FORM

IEAP requests that providers fax this completed form within 48 hours of the initial EAP assessment sessions. The Patient will have been instructed by phone and in the *Explanation Of Benefits and Release of Information form* to contact IEAP prior to continuing treatment. IEAP cannot direct and authorize treatment without this information and IEAP will not pay for EAP sessions until this has been received. (*This form is not required on EAP only accounts*).

D. PROVIDER BILLING FORM

The EAP authorization letter serves as the billing form, and will be mailed to the provider upon receiving a referral from Interface EAP. Sessions authorized through the EAP are not insurance services and cannot be billed as such. To receive prompt payment for seeing an IEAP patient, for the initial EAP assessment or for the limited number of subsequent EAP sessions authorized, an *EAP Billing form* must be used. IEAP will not be able to process any *Provider Billing forms* without the completed and signed *Release Of Information* and the *Clinical Feedback forms* being on file with IEAP (*see EAP Billing Procedure*). On EAP only accounts, the only paperwork required is the EAP billing form with quality assurance section completed. Please verify that all information captured on the billing form is correct, provide dates of service in the boxes provided, complete quality assurance information, and mail to IEAP for payment.

E. MANAGED CARE PROVIDER RESPONSIBILITIES AND BILLING PROCEDURES

This form is supplied to providers and outlines the providers responsibilities regarding referrals made under the patients insurance. It also provides information on billing procedures and information that IEAP requires when submitting claim forms. This form is for referrals made under the patient's insurance plan and not the EAP.



INTERFACE EAP

WWW.IEAP.COM

EMPLOYEE ASSISTANCE PROGRAMS – MENTAL HEALTH CARE MANAGEMENT

Patient Rights and Responsibilities

As a patient of Interface EAP you have certain rights:

- You have the right to dignity as an individual human being.
- You have the right to equal consideration and treatment regardless of your sex, age, race, religion, color, economic status, or sexual preference.
- You have a right to be provided with professional and respectful care.
- You have the right to confidentiality. No information will be released without your written consent except as required by law. In general, imminent issues of suicide, homicide and child abuse require actions (and release of information) without your consent. There are other specific areas of the law that may limit your right of confidentiality. You may ask your counselor about these limitations.
- You have the right to know our assessment of the problem, the recommended treatment plan, and resources available to help improve this problem.
- You have the right to refuse treatment. Even though your counselor may strongly suggest you seek help, you may choose to not follow the counselor's advice. Should you choose to refuse treatment you will be advised of the consequences that may result from your refusal. Alternatives forms of treatment or help may be available.

Along with these rights go certain responsibilities. These are:

- To be honest, open and willing to share your concerns with your counselor
- To ask questions when you do not understand or need clarification
- To discuss any reservations you have about your treatment plan with your counselor
- To follow the agreed-upon treatment plan.
- To report changes or unexpected events as related to your problem with your counselor
- Keep appointments whenever possible and to call and cancel within 24 hours prior to your appointment, otherwise you will lose that session from the total number of sessions allowed per year under the EAP.
- Remember, you are responsible for your thoughts, feelings, actions, and your growth. We are here to help you to the best of our ability.

THIS FORM IS FOR THE PATIENT AND THERAPIST'S USE ONLY



INTERFACE EAP

www.ieap.com

EMPLOYEE ASSISTANCE PROGRAMS – MENTAL HEALTH CARE MANAGEMENT

EXPLANATION OF EAP AND RELEASE OF INFORMATION

PROVIDER MUST SUBMIT A COPY OF THIS SIGNED FORM TO RECEIVE PAYMENT FOR EAP SESSIONS.
PATIENT MUST RECEIVE A COPY OF THIS FORM

Patient Name: _____ **IEAP Case #:** _____
Please print -REQUIRED *REQUIRED*

Provider Name: _____
Please print -REQUIRED

DESCRIPTION OF SERVICE: Your employer has contracted with Interface EAP to provide you and your eligible dependents an Employee Assistance Program (EAP) to handle assessment and treatment of short-term problems. This benefit is free to you and sessions are limited in number according to your employer’s contract.

Interface EAP has authorized **two** of your available EAP sessions to this provider in order to assess the problem and make recommendations on the type and length of treatment needed to resolve your individual problem.

It is your responsibility to contact Interface EAP before any additional sessions will be authorized. After your second visit with the provider, you will need to call an Interface care coordinator at 713-781-3364 or 1-800-324-4327 to discuss treatment recommendations. It is best to call Interface EAP (2) two working days AFTER you have had your second session with this therapist. Additional unauthorized sessions will be your financial responsibility.

TREATMENT RECOMMENDATIONS: Your provider will recommend a course of treatment, which may include: use of your remaining EAP sessions, a referral to a community resource, or, in some cases, a referral for long-term treatment under your health insurance benefits. If your health insurance option is chosen, it is your responsibility to check eligibility, deductible, and copay through your insurance plan.

CONFIDENTIALITY: Use of the EAP benefit is confidential. Interface EAP cannot release any information about you without your prior written consent or as required by law. Your provider will be able to answer any questions or concerns you may have.

GRIEVANCE PROCEDURE: If you are dissatisfied with the service you receive, you may register your complaint by telephone or mail. Write to Interface EAP at P.O. Box 421879, Houston, TX 77242-1879, or call (713) 781-3364 or 1-800-324-4327.

I have reviewed and understand the information above. By signing this form, I agree to allow the results of this assessment, including clinical and referral information, to be disclosed to an Interface EAP care coordinator for the purpose of authorizing additional care and process EAP billing.

Patient’s Signature (If under 18, signature of parent, guardian or authorized representative) REQUIRED *Date*

Witness or Provider Signature REQUIRED *Date*

You may withdraw your consent at any time. Any withdrawal of consent will not affect the legality of any release of information, which has already taken place due to this signed document. If not revoked sooner in writing, this consent will expire one year from the date signed. A copy of this release is valid.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stated in this consent. Any other use of the information without the expressed written consent of the patient is prohibited. These records may be protected by Federal Regulation (42 CFR Part 2).

INTERFACE EAP – CLINICAL FEEDBACK FORM

VOICE: 800-324-4327 or 713-781-3364

SECURE CLINICAL FAX: 800-304-4838 or 713-781-4954

This form is used to provide Interface EAP with clinical information and to request authorization.

Patient's First Name: _____ **Case Number:** _____

Provider: _____ **Date Form Submitted:** _____

I. Date(s) of sessions covered in this report: _____

II. Diagnoses

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: Stressors: _____

Axis V: Current GAF: _____ Highest GAF past year: _____

III. Current Symptoms And Severity: Symptoms in remission due to medication

IV. Relevant History: No additional data since last clinical update

V. Current Medications And Dosages: No current psychotropic medications

VI. Patient's Current Level Of Risk (include data on history and any plan):

A. Suicide: [1] Probability: None Low Moderate High

[2] Plan: None Specific Plan: _____

[3] Intent: None Level of Intent: _____

B. Significant Violence Toward Others:

[1] Probability: None Low Moderate High

[2] Plan: None Specific Plan: _____

VII. Proposed Treatment Plan (D & E must be completed for long-term cases):

A. Estimated length of treatment: _____ Chronic condition -- indefinite treatment

B. Goals to be met before termination of treatment: _____

C. How are goals to be measured? _____

D. Progress since start of treatment? Completed _____ % of goals as evidenced by: _____

E. Anticipated step-down date: _____ Step-down frequency? _____

F. Patient's response to treatment Poor Marginal Fair Good Excellent

VIII. Action Requested (must be completed for authorization):

Request remaining _____ EAP sessions & Close Case (limited number; free to pt; not available in all cases)

OR

Long Term Issue: Request use of Insurance Benefits (uninterrupted care for duration of treatment)

1. CPT Code: _____ Frequency: _____ Number: _____

2. CPT Code: _____ Frequency: _____ Number: _____

Referral to: _____ For: _____

Close case - No further treatment necessary

CONFIDENTIALITY NOTICE

The information contained in this document is legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this document is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this document is strictly prohibited. If you have received this document in error, please immediately notify us by telephone and return the original document to us at the address above via the United State Postal Service. Thank you.



INTERFACE EAP
Total Life Assistance

www.ieap.com

[Current Date]

EAP Authorization and Billing Form
Initial EAP Sessions

Clinician Name
Clinic Name
Mailing Address
City, State Zip Code

Interface EAP (IEAP) is authorizing [Session #] sessions for assessment of the following referral:

Patient: [Participant Name] **IEAP Case:** [Case Number]

Please fax the following **required** IEAP forms within 24 hours of initial sessions:

- Completed Clinical Feedback Form to request additional EAP **OR** insurance authorization
- Signed Explanation of EAP - Release of Information Form

Please Remember:

- EAP sessions are free to the patient.
- Do NOT send any form of correspondence, billing statements or notices to patient.
- Patient is NOT financially responsible for any EAP sessions not paid due to failure on your part to submit required forms or obtain additional authorizations.
- After your assessment, the patient **MUST** re-contact IEAP. Your recommendations will be reviewed with the patient. If your recommendations are for "short-term" treatment, IEAP will authorize remaining EAP sessions (*number available varies*). If your recommendations are for "long-term" treatment, IEAP will allow patient the choice of **EITHER** using their remaining free EAP sessions **OR** requesting authorization of insurance services. IEAP can only authorize insurance services if IEAP is the managed care company for the plan.

IEAP will pay 100% of your contracted **EAP Rate [EAP Rate]**. **Billing must be received at IEAP within 90 days of each date of service to be considered for payment.** Bills received by the 10th of the month will be processed by the last business day of that month.

Insert Date(s) of Session in boxes below (*date must be complete and include year MM/DD/YY*).

MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
----------	----------	----------	----------

Signature _____
Clinician Name and Degree

Mail this form to:
Attention: EAP Billing
PO Box 421879
Houston, TX
Auth Code: XX

Federal EIN: **Clinician EIN**
IEAP Internal ID: **IEAP ID**
Check made payable **Clinician Name**
Check mailed to: **Mailing Address**
 City, State Zip Code

THIS FORM WILL NOT BE ACCEPTED VIA FAX

The information contained in this facsimile document is legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of the message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copy of this facsimile is strictly prohibited. If you have received this message in error, please immediately notify IEAP via telephone and return the original message to us at the address shown above via the U.S. Postal Service. Thank you.



INTERFACE EAP

Total Life Assistance

www.ieap.com

Current Date

Authorization Billing Form
EAP Treatment

Clinician Name
Clinic Name
Mailing Address
City, State Zip Code

You are authorized [# of Sessions] session(s) not to exceed one per week for assessment and brief resolution therapy for:

Patient: [Participant Name] IEAP Case: [Case Number]

Please Remember:

- EAP sessions are FREE and CONFIDENTIAL. Do NOT send any correspondence/billing notices to patient.
- If you determine this patient requires care beyond the available authorized EAP sessions, it is your responsibility to assist patient with referral using available health benefits or community resources.

IEAP will pay 100% of your contracted EAP Rate [EAP Rate]. **Billing must be received at IEAP within 90 days of each date of service to be considered for payment.** Bills received by the 10th of the month will be processed by the last business day of that month.

Insert Date(s) of Session in boxes below (date must be complete and include year MM/DD/YY).

MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY

I have explained this patient's rights regarding confidentiality and have obtained a signed consent form, which allows me to provide the above information and to receive payment for counseling that occurred on the above dates. I have explained to this patient that Interface EAP provides this employer sponsored benefit and that Interface EAP may be contacted by phone or mail to register any complaints related to this benefit or my services.

Signature: _____ [Clinician Name and Degree]

Mail this form to: IEAP
Attention: EAP Billing Dept.
PO Box 421879
Houston, TX 77242-1879
Auth Code: XX

Federal EIN: [Clinician's EIN]
IEAP Internal ID: [Clinician's IEAP ID]
Check made payable: [Contract Name]
Check mailed to: [Clinician's mailing address]
[City, State Zip Code]

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Interface EAP

PO Box 421879, Houston, Texas 77242-1879
713/781-3364 800/324-4327

MANAGED CARE PROVIDER RESPONSIBILITIES and BILLING PROCEDURES

DEFINITIONS

- TPA** Third Party Administrator - manages self-funded insurance plan. TPA's will verify eligibility, benefit limitations including excluded modalities as well as pay claims authorized and processed by IEAP
- IN-NETWORK** Refers to providers with whom IEAP has a valid contract. Some insurance plans will reimburse at a higher level for in-network providers
- OUT-OF-NETWORK/
NON-NETWORK** Refers to providers with whom IEAP has no valid contract. Some insurance plans will not reimburse or reimburse at a lower rate for out-of-network providers

IEAP FORMS

- Clinical Feedback Form
- Hospital Admission Form (*sent to hospitals only*)

PROVIDER RESPONSIBILITIES

The provider MUST:

- VERIFY patient's benefits with the TPA under the health plan -- participant coverage, treatment for diagnosis and CPT Code coverage, and any limitations with regards to: provider credentials, maximum number of sessions allowed, the submission of billings, time limitations, forms needed, etc.
- PREAUTHORIZE all treatment with Interface EAP -- this includes all in-network as well as most out-of-network cases. Failure to obtain precertification of treatment may result in a significant reduction in the level of available insurance reimbursement.
- REFER participant to IEAP for any other necessary treatment referrals (*i.e. hospitalization, medication evaluations, psychological testing, etc.*)

BILLING PROCEDURES

Use your regular insurance forms to file all claims

- Indicate your standard fee on insurance claim form (*IEAP will make adjustments based on your contracted rate and forward your claim to the TPA for review of benefits*)
- Include the following clean claim elements to insure prompt reimbursement:
 - * IEAP Case Number
 - * Patient Name
 - * Patient Date Of Birth
 - * Name Of Covered Employee
 - * Social Security Number Of Covered Employee
 - * Proper CPT Code For Treatment Provided
 - * Participant's DSM IV - TR Diagnostic Code
 - * Employer Name

Submit ALL insurance claims to IEAP for processing. Interface will reprice per contracted rate and forward to TPA (claims mailed directly to TPA may result in a denial of benefits)

IMPORTANT NOTE: IEAP'S AUTHORIZATION IS BASED SOLELY ON MEDICAL NECESSITY AND DOES NOT GUARANTEE INSURANCE COVERAGE OR PAYMENT ON CLAIMS SUBMITTED.