

CLIENTS WITH AN EMPLOYEE ASSISTANCE PROGRAM

Please complete the following information:

Name of EAP insurance company: _____

Telephone number of EAP insurance company: _____

Authorization number: _____

How many visits are authorized? _____

Effective dates: _____ / ____ / ____ to _____ / ____ / ____

I understand, that if this information is not provided, my regular insurance company will be billed and I may be responsible for a copayment.

Signature of client: _____

Date: _____