Attachment 1
Self-Referral Waiver

I have been receiving services from ______________________________ ("Provider") through an Employee Assistance Program (EAP) provided by Magellan Health Services or one of its affiliates, including Magellan Behavioral Health, Inc., Human Affairs International of California, and Magellan Health Services of California, Inc.—Employer Services (formerly Vista Behavioral Health Plans) (referred to collectively as "Magellan").

I understand that it is my provider's judgment that my issues cannot be resolved through the brief counseling or other services available through the Employee Assistance Program (EAP) and that I therefore need treatment beyond the services available through the EAP.

I understand that Magellan has the capability to refer me to an appropriate clinician in my community to furnish ongoing treatment. However, I choose to see this provider in his/her private practice for ongoing treatment. I understand that I will be responsible for payment for all services provided by the provider after ________________________, 200____ and that if I desire reimbursement under my benefit plan, I am responsible for determining whether or not the treatment rendered by the provider will be covered under the benefit plan. Magellan does not guarantee that such treatment will be covered under the benefit plan.

I also understand that the provider is solely responsible for my treatment from the date specified in the previous paragraph and that Magellan has no connection whatsoever with the treatment I will receive from such provider.

I give my permission for a copy of this form to be sent to Magellan.

______________________________	______________________________
Witness	Print name of member
______________________________	______________________________
Date	Signature of member
______________________________	______________________________
Name of employer paying for EAP	Address