

Employee Assistance Service Information Form (EASI Form)

Please confirm all information. If information is incorrect, call Magellan to rectify.

Instruction: In order to receive payment for this case, you must complete the information requested on both pages of this form. Mail the completed form within 90 days of the end date on the Magellan face sheet. Please refer to the client's original EAP registration for billing address.



MIS#: _____ TIN/SSN: _____

Clinician: _____ (Provide TIN/SSN for payment)

Agency/Organization: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Case # / MAT #: _____

Client Name: _____ SSN: _____

Magellan's Client Organization _____

1. Please enter "Time Seen" in minutes if the session was beyond the standard. Standard payment is based on a 45-55 minute session. Sessions beyond the standard MUST be preauthorized.

Session Date(s) MM / DD / YY			Time Seen (in minutes)	Start Time of Appt (24 hr clock)	Number Present	Attendees			
						Employee	Spouse	Dependents	Other
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please complete the following by filling the circle (or square) that corresponds with the appropriate answer.

2. Is this bill: an interim bill? a final bill?

3. Race/Ethnicity of client: (select only one)

Caucasian African American Hispanic Asian Native American Other Declined

4. Assessed Problem: (Mark for primary assessed problem, for secondary problem [optional])

- | | | | |
|--|---|---|--|
| 01 <input type="checkbox"/> Alcohol | 82 <input type="checkbox"/> Depression | 251 <input type="checkbox"/> Trauma | 13 <input type="checkbox"/> Work Performance |
| 02 <input type="checkbox"/> Illicit Drug | 19 <input type="checkbox"/> Med/Physical | 15 <input type="checkbox"/> Childcare | 286 <input type="checkbox"/> Occupational Stress |
| 03 <input type="checkbox"/> Rx Drug | 10 <input type="checkbox"/> Marital | 83 <input type="checkbox"/> Eldercare | 08 <input type="checkbox"/> Domestic Violence |
| 04 <input type="checkbox"/> Polydrug | 87 <input type="checkbox"/> Bereavement | 16 <input type="checkbox"/> Legal | 11 <input type="checkbox"/> Interpersonal Relationships |
| 06 <input type="checkbox"/> Eating Disorder | 12 <input type="checkbox"/> Family/Children | 17 <input type="checkbox"/> Financial | 14 <input type="checkbox"/> Family/Friend Emot/Health |
| 269 <input type="checkbox"/> Anxiety | 271 <input type="checkbox"/> OtherPsychological | 18 <input type="checkbox"/> Career Planning | 07 <input type="checkbox"/> Other Compulsive Disorder |
| 05 <input type="checkbox"/> Family/Friend Alc/Drug | | 249 <input type="checkbox"/> School Related | 280 <input type="checkbox"/> Learning/Development Issues |

5. Referred to: (select all that apply)

- 002 Substance Abuse: Inpatient Care
- 004 Substance Abuse: Outpatient Care
- 200 Substance Abuse: Alternative Level of Care
- 005 Behavioral Health: Inpatient Care
- 007 Behavioral Health: Outpatient Care
- 201 Behavioral Health: Alternative Level of Care
- 019 Financial Services
- 113 Child Care Referral
- 114 Elder Care Referral
- 020 Legal Services
- 021 Medical/Physical
- 022 Community Social Services
- 202 Twelve-Step Programs
- 087 Educational Services
- 046 Career Counseling
- 023 No Referral Made
- 075 Declined Referral

6. Statement of Understanding:

- 001 Member signed
- 002 Member refused to sign
- 003 Not asked to sign (reason) _____
- 004 Other signed

Case # / MAT #: _____

7. Client Satisfaction Survey:

- 001 Given to client
- 002 Not given to client
- 003 Not applicable (under 16)

8. In the past 4 weeks as a result of EAP Counseling:

Employee Only: (If employed by organization providing Magellan EAP)

What percentage of improvement did the employee experience in routine work capacity +/-

_____ %

What percentage of improvement did the employee experience in activities of daily living +/-

_____ %

How many days might have been missed from work if the employee had not had this EAP counseling (specific 0-28) _____ day(s)?

Dependent, retiree or other household members only

In the past 4 weeks as a result of EAP counseling:

What percentage of improvement did the client experience in activities of daily living +/-

_____ %

- 9. Alcohol/Other Drug (AOD) Screening completed?** Yes No
Child under 12? Yes No

10. Risk of Harm

1. Threat of Violence (TOV) level:
- 1 - None
 - 2 - Possible threat mentioned, no current danger
 - 3 - Threat made, violence possible
 - 4 - Active threat of violence exists
 - 5 - Client dangerous to self/others

(If TOV between 3 - 5, then answer a and b, below)

- a. Staffed with Magellan? Yes No NA
- b. Action plan developed? Yes No NA
- 2. Duty to warn issues? Yes No
- 3. Risk of workplace violence? Yes No

11. The client's level of functioning prior to the first session could best be described as:

- Overall** Poor Below average Good Above average Excellent
- Social** Poor Below average Good Above average Excellent
- Work** Poor Below average Good Above average Excellent NA

The client's level of functioning after the last session could best be described as:

- Overall** Poor Below average Good Above average Excellent
- Social** Poor Below average Good Above average Excellent
- Work** Poor Below average Good Above average Excellent NA

12. ICD-9 Assessment

_____ Primary Dx _____ Secondary Dx

13. The information above accurately reflects the services I delivered

Clinician Signature Date MM / DD / YY

Telephone Number _____
Extension

Magellan Health Services

Midwest Office
14100 Magellan Plaza
Maryland Heights, MO 63043
800-858-2771

California Office
PO Box 950
El Segundo, CA 90245
310-726-7055