Employee Assistance Service Information Form (EASI Form)

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

Instructions: In order to receive payment for this case, you must complete the information requested on both pages of this form. Fax or mail the completed form within 90 days of the end date on the Magellan referral sheet. *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:____________________ Magellan's Client Organization:____________________

Mandatory		MM/DD/YY
	Date the member contacted you for the first session	__ __ / __ __ / __ __
	Date of the first available appointment offered (even if the member did not accept)	__ __ / __ __ / __ __

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 (minutes)	Start Time Appt (24 hr clock)	Number Present	Attendees: Employee	Spouse	Dependents	Other	Session Administration: In Person	Telehealth
__ __ / __ __ / __ __				☐	☐	☐	☐	☐	☐
__ __ / __ __ / __ __				☐	☐	☐	☐	☐	☐
__ __ / __ __ / __ __				☐	☐	☐	☐	☐	☐
__ __ / __ __ / __ __				☐	☐	☐	☐	☐	☐
__ __ / __ __ / __ __				☐	☐	☐	☐	☐	☐
__ __ / __ __ / __ __				☐	☐	☐	☐	☐	☐
__ __ / __ __ / __ __				☐	☐	☐	☐	☐	☐
__ __ / __ __ / __ __				☐	☐	☐	☐	☐	☐

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 ○☐ Alcohol	**82** ○☐ Depression	**251** ○☐ Trauma	**13** ○☐ Work Performance
02 ○☐ Illicit Drug	**19** ○☐ Med/Physical	**15** ○☐ Child Care	**286** ○☐ Occupational Stress
03 ○☐ RX Drug	**10** ○☐ Marital	**83** ○☐ Elder Care	**08** ○☐ Domestic Violence
04 ○☐ Polydrug	**87** ○☐ Bereavement	**16** ○☐ Legal	**11** ○☐ Interpersonal Relationships
06 ○☐ Eating Disorder	**12** ○☐ Family/Children	**17** ○☐ Financial	**14** ○☐ Family/Friend Emo/Health
269 ○☐ Anxiety	**271** ○☐ Other Psychological	**18** ○☐ Career Planning	**07** ○☐ Other Compulsive Disorder
05 ○☐ Family/Friend Alc/Drug		**249** ○☐ School Related	**280** ○☐ Learning/Development Issues

Magellan HEALTHCARE®

For faster reimbursement...

Instead of filling out this form, **go to our website app to quickly complete online!**

Sign in to MagellanProvider.com and select *Submit an EASI Form* from the left menu.

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. Member Experience 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? (specify 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-10 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 Healthcare
Midwest Office
(Includes BSC EASI Form)
Attn: Affiliate Specialist, MO02
P.O. Box 1899
Maryland Heights, MO 63043
Fax: 1-800-858-2771

Federal Programs
Attn: Affiliate Specialist, MO22
P.O. Box 1899
Maryland Heights, MO 63043
Fax: 1-888-656-5032

California Office
(For use in CA for non-BSC EASI Forms)
P.O. Box 710430
San Diego, CA 92171
Fax: 1-888-656-4789

For help completing this form, see the EASI Form Instructions, online at www.MagellanProvider.com/EAP – see Appendix A: EAP Forms

©2005-2024 Magellan Health, Inc. rev. 11/24