

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	Date the member contacted you for the first session	MM/DD/YY <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>												
Date of the first available appointment offered (even if the member did not accept)	MM/DD/YY <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table> / <table border="1" style="display: inline-table; width: 40px; height: 20px;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>													

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				Session Administration	
				Employee	Spouse	Dependents	Other	In Person	Telehealth
				<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"/>	<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"/>

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"/> Child Care | 286 <input type="checkbox"/> Occupational Stress |
| 03 <input type="checkbox"/> RX Drug | 10 <input type="checkbox"/> Marital | 83 <input type="checkbox"/> Elder Care | 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 Emo/Health |
| 269 <input type="checkbox"/> Anxiety | 271 <input type="checkbox"/> Other Psychological | 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 |



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:
- | | |
|--|--|
| <input type="radio"/> 1 – None | <input type="radio"/> 3 – Threat made, violence possible |
| <input type="radio"/> 2 – Possible threat mentioned, no current danger | <input type="radio"/> 4 – Active threat of violence exists |
| | <input type="radio"/> 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)
14100 Magellan Plaza
Maryland Heights, MO 63043
Fax: 1-800-858-2771

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

Federal Occupational Health
Attn: Affiliate Specialist, MO22
14100 Magellan Plaza
Maryland Heights, MO 63043
Fax: 1-888-656-5032

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