Samaritan
Center of Puget Sound

EAP Information
(Employee Assistance Program)

Client:

First Name _____ Last Name _____

Social Security # _____ Birth Date _______________

Gender: Male_____ Female_____

Marital Status: Single_____ Married_____ Other_____

I authorize the release of any medical or other information necessary to process this claim or any further claims.

_____ Date_____
Client or Authorized Person's Signature

I authorize payment of EAP benefits to Samaritan Center of Puget Sound.

_____ Date _____
Insured or Authorized Person's Signature

EAP Information: To Be Completed by Therapist

Therapist Bills_____ Office Bills_____

Number of sessions authorized:_____ Authorization Dates: From_____ to_____

Authorization Number:_____

Client Relationship to Insured: Self_____ Spouse_____ Child_____ Other_____

EAP Company:_____

EAP Address: _____

Phone Number: _____

Employer Name: _____

Therapist: _____

Diagnosis: _____