



**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: \_\_\_\_\_