



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: _____