The Holman Group
Managed Behavioral Health Care Services

For **EAP Billing Only** ReturnTo:
9451 Corbin Avenue, Suite 100
Northridge, CA 91324
818.704.1444

Attn: EAP

Provider:	Employee:
Soc. Sec.#:	Soc. Sec.#:
Address:	Patient:
City, State, Zip Code:	Relationship:
Telephone:	Employer/Union:

** **Reminder:** Client's Clinical Assessment form must be on file with The Holman Group.

1. Please have client sign the Authorization for Release of Information on the reverse side of this form.
2. Please make a copy of the signed forms for your own files.
3. Please use this form to bill all EAP/MAP sessions.
4. You do not need to wait until all sessions are completed before billing.
5. Please do not bill insurance sessions on this form. Authorized insurance sessions may be billed on the insurance billing form that you will receive in your Provider Packet. If you prefer, you may bill the insurance sessions on your own billing form.
6. Authorization for any further sessions must be preauthorized. Call the Care Management Department for further instructions.
7. Remember that if client's treatment goes beyond EAP/MAP sessions a claim form, copayment, and/or deductible may be required.
8. No-Show/Late Cancellation Policy - Please refer to your provider manual or call the Provider Relations Department.
9. Broadened EAP accounts may require a copayment.

Diagnosis:
Diagnosis:
Date of Visit:
Date of Visit:
Date of Visit:
Date of Visit:
Date of Visit:

Holman Contract Rate: $__________________

Copayment Collected: $__________________
(Broadened EAP accounts only)

Visits x Rate - Copayment = Fee: $__________

Total Amount Due: __________________

Provider's Signature:

____

The
HOLMAN
Group

Request and Authorization for the Release of Information

Assignment of Benefits Authorization

I understand that in order to assure the quality of services provided to me under the EAP/MAP/HMO, information regarding my medical records, my personal history (and/or family's), reports of psychological tests (which may have been administered), and diagnosis and plan or treatment reports, may be **confidentially reviewed** by a committee of professionals known as the Utilization Management Committee (UMC) and/or professional representatives of The Holman Group Quality Management (QM) staff.

I have discussed these procedures with ______________________________ who is authorized to provide relevant information to the Utilization Management Committee follow-up counselor. This confidential information will be used to assure the quality of service you receive, ensure payment for authorized services is properly processed and to ensure the proper delivery of health care services. This information will not be used for any other purposes.

I understand that this review will be for the purpose of planning and evaluating the services being made available to me and this information shall not be released to any other person, organization or company.

I understand that during and after my counseling, I will be receiving a follow-up call and/or questionnaire from The Holman Group. The purpose of this follow-up call will be to further assure that I received the assistance that I wanted.

I understand that this release of confidential medical information shall be valid for the period of my coverage under this group plan and that information obtained under this release will be used only for the furtherance of my treatment and in determining my benefits. The Holman Group will maintain the information provided for a period of seven years for adults and ten years for minors. After the expiration of this time, the information provided will be destroyed in a confidential manner.

I understand that if I reveal information concerning child abuse, intent to harm myself or others, or abuse to the elderly, the therapist/counselor is mandated by law to report it. All other matters will remain strictly confidential and privileged, except for purposes of professional review and follow-up.

I, the undersigned person, assume full personal financial responsibility for any psychological and counseling services rendered, other than the EAP sessions which are contractually provided by The Holman Group.

I hereby authorize the payment of medical benefits to The Holman Group for services rendered to me.

I have received a copy of this Request and Authorization for Release of Information and hereby waive any additional reporting requirements governing notification during the process of exchanging information between The Holman Group and my provider during the course of my treatment.

I understand that a photocopy/facsimile of this Request and Authorization shall be as valid as the original.

Requested By:

Stephen Klevens, M.D., Medical Director, The Holman Group Representative

Enrollee Signature: ______________________________ Date: ____________________