



**Attn: EAP**

Provider:
Soc. Sec.#:
Address:
City, State, Zip Code:
Telephone:

Employee:
Soc. Sec.#:
Patient:
Relationship:
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:
Date of Visit:

Holman Contract Rate: \$ \_\_\_\_\_

Copayment Collected: \$ \_\_\_\_\_  
(Broadened EAP accounts only)

# Visits x Rate - Copayment = Fee: \$ \_\_\_\_\_

Total Amount Due: \_\_\_\_\_

Provider's Signature:  
\_\_\_\_\_