

PLEASE PRINT OR TYPE

Therapist Name:		Authorization Number:	
Email:		Date of Referral:	

PROGRAM UTILIZATION FORM

EMPLOYEE DATA <small>(Pertains to the employee who is covered by the EAP.)</small>	CLIENT DATA <small>(Pertains to the person being seen)</small>																																																																												
<p>Company Name: _____</p> <p>Name: _____</p> <p>Job Category:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Management</td> <td><input type="checkbox"/> Technical</td> <td><input type="checkbox"/> Service</td> </tr> <tr> <td><input type="checkbox"/> Supervisor</td> <td><input type="checkbox"/> Clerical</td> <td><input type="checkbox"/> Sales</td> </tr> <tr> <td><input type="checkbox"/> Professional</td> <td><input type="checkbox"/> Production</td> <td><input type="checkbox"/> Labor/ Unskilled</td> </tr> </table> <p>Other _____</p> <p>Length of Service with Employer:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> < 6 months</td> <td><input type="checkbox"/> 6-10 years</td> <td><input type="checkbox"/> 21+ years</td> </tr> <tr> <td><input type="checkbox"/> < 1 year</td> <td><input type="checkbox"/> 11-15 years</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 1-5 years</td> <td><input type="checkbox"/> 16-20 years</td> <td></td> </tr> </table> <p>Date Seen: _____ "X" for No Show</p> <table style="width:100%; border: none;"> <tr><td style="width:15%; text-align: center;">/</td><td style="width:15%; text-align: center;">/</td><td style="width:15%;"></td><td style="width:15%;"></td><td style="width:15%;"></td><td style="width:15%;"></td></tr> <tr><td style="text-align: center;">/</td><td style="text-align: center;">/</td><td></td><td></td><td></td><td></td></tr> <tr><td style="text-align: center;">/</td><td style="text-align: center;">/</td><td></td><td></td><td></td><td></td></tr> <tr><td style="text-align: center;">/</td><td style="text-align: center;">/</td><td></td><td></td><td></td><td></td></tr> <tr><td style="text-align: center;">/</td><td style="text-align: center;">/</td><td></td><td></td><td></td><td></td></tr> <tr><td style="text-align: center;">/</td><td style="text-align: center;">/</td><td></td><td></td><td></td><td></td></tr> </table>	<input type="checkbox"/> Management	<input type="checkbox"/> Technical	<input type="checkbox"/> Service	<input type="checkbox"/> Supervisor	<input type="checkbox"/> Clerical	<input type="checkbox"/> Sales	<input type="checkbox"/> Professional	<input type="checkbox"/> Production	<input type="checkbox"/> Labor/ Unskilled	<input type="checkbox"/> < 6 months	<input type="checkbox"/> 6-10 years	<input type="checkbox"/> 21+ years	<input type="checkbox"/> < 1 year	<input type="checkbox"/> 11-15 years		<input type="checkbox"/> 1-5 years	<input type="checkbox"/> 16-20 years		/	/					/	/					/	/					/	/					/	/					/	/					<p>Client Name: _____ <small>(May be employee)</small></p> <p>Relationship To Employee:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Self</td> <td><input type="checkbox"/> Family Member</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other _____</td> </tr> </table> <p>Age of Client:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> 0-25</td> <td><input type="checkbox"/> 46-55</td> </tr> <tr> <td><input type="checkbox"/> 26-35</td> <td><input type="checkbox"/> 56+</td> </tr> <tr> <td><input type="checkbox"/> 36-45</td> <td></td> </tr> </table> <p>Presenting Problems:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Alcohol</td> <td><input type="checkbox"/> Alcohol/Family Member</td> </tr> <tr> <td><input type="checkbox"/> Drugs</td> <td><input type="checkbox"/> Job Performance</td> </tr> <tr> <td><input type="checkbox"/> Financial</td> <td><input type="checkbox"/> Family/ Child</td> </tr> <tr> <td><input type="checkbox"/> Medical</td> <td><input type="checkbox"/> Marital/Relationship</td> </tr> <tr> <td><input type="checkbox"/> Legal</td> <td><input type="checkbox"/> Emotional</td> </tr> <tr> <td><input type="checkbox"/> Work Stress</td> <td><input type="checkbox"/> Other _____</td> </tr> </table> <p>Case Closed: Yes No</p> <p>Date Closed: _____</p>	<input type="checkbox"/> Self	<input type="checkbox"/> Family Member	<input type="checkbox"/> Other _____		<input type="checkbox"/> 0-25	<input type="checkbox"/> 46-55	<input type="checkbox"/> 26-35	<input type="checkbox"/> 56+	<input type="checkbox"/> 36-45		<input type="checkbox"/> Alcohol	<input type="checkbox"/> Alcohol/Family Member	<input type="checkbox"/> Drugs	<input type="checkbox"/> Job Performance	<input type="checkbox"/> Financial	<input type="checkbox"/> Family/ Child	<input type="checkbox"/> Medical	<input type="checkbox"/> Marital/Relationship	<input type="checkbox"/> Legal	<input type="checkbox"/> Emotional	<input type="checkbox"/> Work Stress	<input type="checkbox"/> Other _____
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Billing Inquires: To ensure timely response, please submit all inquiries via fax or email (above). DO NOT submit duplicate Program Utilization Forms.

Case Closed: Provider may submit billing up to 30 days after final DOS or after each session. **Reimbursement Policy:** By submitting this form provider acknowledges ACI Billing Policies.

Per ACI Provider Contract; unauthorized services or billing will not be reimbursed, billing received beyond 30 days from last date of sessions cannot be reimbursed.

HAS YOUR CONTACT OR PAYMENT INFORMATION CHANGED?

Email: provider-relations@acieap.com

Please remit a corrected/ revised W-9 to ACI Provider Relations (Include email, tel. & fax updates with W-9)

06292010V3

To ensure continued panel participation remit updated licensing & malpractice insurance after each renewal.