



## Employee Assistance Program Claim Form

To determine payment for Employee Assistance Program (EAP) claims, HMAA requires the following information. If additional space is needed, please attach a sheet. Failure to submit complete information or a signature may result in the delay or denial of claim payment. If you have questions, please contact our Customer Service Center.

Member ID Number*	Group Policy Number	Date(s) of Service	Referral Reason Code(s) **	Days or Units	\$ Charges
<b>Total</b>				<b>\$</b>	

\* Please do **not** include the member or patient's name on this form.

**\*\* Referral Reason Codes:**

1. Work-Related: Company changes (e.g., downsizing)
2. Work-Related: Interpersonal problems with supervisor and/or co-workers
3. Substance Abuse (e.g., drug or alcohol-related)
4. Family relationship (e.g., parenting issues)
5. Loss of a significant other
6. Financial concerns
7. Legal concerns
8. Other (specify): \_\_\_\_\_

Federal Tax ID Number	Provider Name
Billing Address	I hereby certify that the information above accurately reflects the services I rendered.  _____
Phone # (    )	Provider Signature <span style="float: right;">Date</span>

**Mail this form to:**

HMAA Claims Department  
PO Box 32580  
Honolulu, HI 96803-2580

Be sure to retain a copy for your records.

**Or fax to:** (808) 591-0463