Integrated Behavioral Health

EAP Claim Form

EMPLOYEE INFORMATION (If any information is missing, please have the patient complete)			
Date	Name		Soc. Sec. Number
Mailing Address	City	State	Zip Code
Home Phone	Employer / Company		

MEMBER INFORMATION			
Name	Birth Date	Gender	Relationship to Employee

CLAIM INFORMATION (To be completed by Provider)	
Member ID Number	Authorization Number

Dates of Service	CPT-4 Code	Length of Session	Amount Charged

PROVIDER INFORMATION			
Name			Phone
Service Address	City	State	Zip Code
Billing Address	City	State	Zip Code
Tax ID Number	NPI Number	License Number	

Signature _____ **Date** _____

In order to process your claim, please include a completed EAP Case Summary.

Mail claim to:
Integrated Behavioral Health
Attn: Claims
P.O. Box 30018
Laguna Niguel, CA 92607-0018

OR

Fax claim to:
(714) 556-5430

For questions, problems or for prior authorization, call IBH at:

1-800-395-1616