HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Phone (808) 941-4622 / Toll-Free (888) 941-4622
CustomerService@hmaa.com

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
				Total	$

* 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 I.D. Number	Provider Name
Billing Address	I hereby certify that the information above accurately reflects the services I rendered.
Phone # ( )	Provider Signature _____ Date _____

Mail this form to:
HMAA Claims Department
PO Box 32580
Honolulu, HI 96803-2580

Be sure to retain a copy for for your records.

Or fax to: (808) 591-0463