HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

737 Bishop Street, Suite 1200
Honolulu, Hawaii 96813
Phone (808) 941-4622 / Toll-Free (888) 941-4622

Employee Assistance Program Claim Form

To determine payment for Employee Assistance Program (EAP) claims, HMAA requires the following information. If additional space is required, please attach a sheet. Upon completion, please sign and date this form, then submit via fax or mail. Make sure to retain a copy for your records. Failure to submit complete information may result in the denial of claim payment. If you have any 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 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 to:
HMAA Claims Department
PO Box 32580
Honolulu, HI 96803-2580

Or fax to: (808) 591-0463