ACI Enterprises Inc.
5405 Morehouse Drive, Suite 200, San Diego, CA 92121
ACI Clinical Dept: clinical@acispecialtybenefits.com
Tel: (855) 775-4357 | Fax: (858) 964-0733

FORMAL MANAGEMENT REFERRAL FORM

PLEASE PRINT OR TYPE

Employee Name:	**Company:**	
Work Location:	**Position:**	**Date of Referral Submission:** / /
Employee Phone #:	**Employee Email:**	**Employee Zip Code:**

Has the employee been suspended from or currently on any sort of leave of absence? If yes, please provide the type of leave and effective date.

Suspended/Leave of Absence: ☐ **Yes** ☐ **No**	**Type of Leave:**	**Effective Date:** / /

Detailed Reason for Referral:

☐ **Standard Referral**	ACI will contact a provider within 2 business days of the submission date above. The employee will contact the referred provider within 3-5 business days to schedule an appointment.
☐ **Urgent Referral***	ACI will contact a provider by the end of the business day immediately following the submission date above. The employee will contact the referred provider within 2-5 business days to schedule an appointment.
☐ **Fitness for Duty**	ACI will contact a provider by the end of the business day immediately following the submission date above. The employee will contact the referred provider within 2-5 business days to schedule an appointment.
☐ **Substance Abuse Professional**	ACI will contact a provider by the end of the business day immediately following the submission date above. The employee will contact the referred provider within 2-5 business days to schedule an appointment.

***Mark urgent only when an employee is in a serious situation, produces a positive drug screen, or is placed on leave until assessed by a provider. If you think the employee may be in a current state to harm him/herself or others, you should call 911 to get assistance from local authorities.**

I understand that my employer has formally referred me to the Employee Assistance Program (EAP) for the above referenced reason. I agree to complete the prescribed number of sessions with the assigned provider from ACI as requested by my employer. Continued employment is based on my employer's policies, not those of ACI Specialty Benefits or those of its network providers. I acknowledge that my signature below indicates my acceptance of these terms.

Employee Signature:		**Date:** / /
HR/Manager Signature:		**Date:** / /
HR/Manager Name:	**HR/Manager Phone #:**	**HR/Manager Email:**

ORIGINAL: HR/Manager
COPY: Employee

PRINT FORM

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RELEASE OF INFORMATION AUTHORIZATION

PLEASE PRINT OR TYPE

HR/Manager: Please fill out Section 7 ONLY.
Employee: Please fill out Sections 1 and 2 ONLY.

SECTION 1: Employee Information

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:** / /
Street Address:	**City:**	**State:**	**ZIP Code:**

SECTION 2: Review Sections 1 through 8, Then Sign Below

I have read the contents of this form. I understand, agree and allow the use and release of my information as I have stated below. I also know that signing this form is of my own free will. I know that the person or company listed in Section 6 does not require that I sign this form in order for me to get treatment or payment, or to sign up for or get benefits. I also know that information that is released may be also given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule.

Employee Signature:	**Date:** / /

SECTION 3: Date Your Approval Expires

Your approval will end one year from the day you sign above.

SECTION 4: Right to Withdraw Your Approval

I have the right to take back my approval at any time by giving written notice to the office listed below. I understand that if I take back this approval, any prior approval that I have already given cannot be withdrawn.

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SECTION 5: Reason for the Release of Information

By signing this form, you will allow ACI to use and give out the information below for the following reasons:

- Assessment to treating professionals only
- Treatment planning
- Determination of compliance with recommendations
- Coordination and continuity of care
- Contract for Continued Employment (CCE)
- Fitness for Duty evaluations

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SECTION 6: Person, Company or Group Allowed to Release the Information

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SECTION 7: Person, Company or Group Allowed to Receive the Information

- Employee Assistance Program professionals
- Treatment providers
- Employer representative (enter employer name, representative name and title below)

Employer Name:

Representative Name:	**Title:**

Additional HR Contacts to Receive Case Updates (Include Name and Email):

SECTION 8: Information Being Released

I approve the following information to be used or given out to the person or company as shown on this form:

- Treatment recommendations to treating health professionals only
- Compliance and/or non-compliance with recommendations
- EAP contact and attendance

I understand that my alcohol/substance abuse information is protected under Federal and State confidentiality laws and regulations. I know it cannot be given out without my written consent unless otherwise provided for in the laws and regulations. I also know that I may withdraw (or cancel) my consent at any time, or as described above in Section 5. I know that I cannot cancel this consent where this form has already been used to give out information.

For Receiver of Substance Abuse Information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please return the completed form to:
ACI Specialty Benefits
5405 Morehouse Drive, Suite 200
San Diego, CA 92121

OR

Fax completed form to:
(858) 964-0733

OR

Email completed form to:
clinical@acispecialtybenefits.com

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