



INTRODUCTION FOR PROVIDERS

Excuse for Absence Process Commonwealth of PA State Employees

A PEBTF member you are seeing has contacted the State Employee Assistance Program (SEAP) to request a possible Excuse for Absence. This individual may be excused from work by a licensed mental health clinician for psychological reasons that impair their ability to perform the job. You can make a clinical recommendation allowing the individual to be away from work for a designated period of time while they address the presenting concerns.

The SEAP Excuse for Absence process is separate from FMLA.
If the employee requests FMLA, please direct them back to their workplace.

Paperwork must be filled out by a licensed mental health clinician. *Documents provided by a medical provider will not be accepted.*

If you are recommending an Excuse for Absence, please follow the steps below:

1. To be eligible, the **employee must first call** into the State Employee Assistance Program (SEAP) (800.692.7459) to discuss care and next steps. The day the employee calls SEAP helps determine an EFA start date. SEAP is available 24/7.
2. **After the initial session**, complete the Excuse for Absence **Initial Clinical Review Form (see page 5)**, which substantiates the recommendation for the Excuse for Absence.
3. Have the employee complete and **sign** the Release of Information Form.
4. Send the completed forms to: **SEAP Management Consultant Team at fax number 866-340-5325 or email SEAP@optum.com.**
5. The case will be **reviewed every two weeks** until the individual is ready to return-to-work. A review date will be provided once the EFA is processed by SEAP. Please plan to complete the Excuse for Absence **Clinical Review Update Form (see page 6)** and send to SEAP every two weeks.
6. When the individual is ready to return to work, please complete the **Clinical Review Update Form** with the return-to-work date and send to SEAP via email or fax.
7. If you have additional questions, you may contact the SEAP Management Consultant Administrator by email at SEAP@optum.com or by calling 800-692-7459. **Please note electronic communication is often the quickest way to receive a response.**

Excuse for Absence Process Guidelines:

- For the duration of the absence, the employee must remain in active treatment and be seen at regular intervals - generally one time per week.
- An EFA does **not** replace or supersede the employer's administration of its leave policies and procedures. It does not determine whether or not the employee will be paid while they are away.
- The employee is expected to follow workplace call-out procedures for the duration of the EFA.
- Our brief **clinical review form** must be completed and returned to the SEAP Management Consultation team by **fax or email every two weeks** until the individual is ready to return to work.
- If SEAP does not receive the Excuse for Absence Clinical Recommendation and the signed ROI forms when treatment begins, it will prevent notification to the individual's workplace resulting in an unexcused absence. **All communication must go through SEAP - at no point should the clinician communicate with the individual's workplace.**
- Please provide advance notice to SEAP of the individual's return to work date so SEAP has adequate time to inform the workplace. If the workplace does not receive advanced notification, return to work may be delayed. Please ensure that the individual knows the return to work date as well.
- Should you have any questions, please do not hesitate to contact SEAP at SEAP@optum.com or by calling 800-692-7459. Please note electronic communication is often the quickest way to receive a response.

To protect the member's confidentiality, *please do not contact the workplace directly.* All communication must be channeled through SEAP.

**ALL STEPS MUST BE FOLLOWED EXACTLY OR YOUR CLIENT RISKS
LOSING THEIR EXCUSED TIME OFF.**

CONFIDENTIAL

EXCUSE FOR ABSENCE AUTHORIZATION FOR THE RELEASE OF INFORMATION

Member Name _____

Birth date _____

Member ID/SS

The undersigned authorizes United Behavioral Health to release to and obtain from:

_____ CDL Program Coordinator(s)
_____ NIDA Certified Laboratory
☒ _____ Office of Administration-SEAP Staff
☒ _____ Agency and/or Field SEAP Coordinator
_____ Manager/Supervisor
_____ Labor Relations/Personnel Officer
_____ Union Representative
☒ _____ Treatment Provider(s)
_____ SEAP Evaluator/SAP
_____ Other: Specify: _____

the following business records and information concerning Patient ("Records"):

<input checked="" type="checkbox"/>	Attendance Only	<input type="checkbox"/>	Substance Dependency Assessment
<input type="checkbox"/>	Social History	<input type="checkbox"/>	Psychology Report
<input type="checkbox"/>	Treatment Plans	<input type="checkbox"/>	Discharge Reports/Summaries
<input type="checkbox"/>	Consultation Report	<input type="checkbox"/>	All pertinent Records UBH deems appropriate for the purpose.
<input checked="" type="checkbox"/>	Other (Describe): <u>Contact with SEAP and clinical recommendation for excuse for absence</u>		

This Authorization ☒ **does** _____ **does not** include Records created by other providers that are in UBH's possession.

The purpose of this release is:

<input checked="" type="checkbox"/>	To allow the clinically appropriate management and coordination of Patient's employee assistance mental health and/or substance abuse services and/or coverage under Patient's health benefit plan.
<input type="checkbox"/>	To allow payment by Patient's third-party payor and as necessary for or related to administration, quality improvement, utilization review and enforcement of the Patient's health benefit plan, including, but not limited to coverage disputes and Patient's continued eligibility.
<input type="checkbox"/>	To keep Patient's parent(s) aware of Patient's treatment
<input type="checkbox"/>	To allow UBH to receive payment from Patient's credit card company.
<input checked="" type="checkbox"/>	Other (Describe): To inform workplace of excuse for absence and return to work schedule

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that by signing below, I am authorizing the release or exchange of these records to the patient named above.

I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying UBH in writing, but if I do, it will not have any effect on any actions UBH took before it received the revocation.

THE MEMBER OR THE MEMBER'S PERSONAL REPRESENTATIVE* MUST READ AND SIGN THE FOLLOWING STATEMENTS:

* A personal representative is an individual who has the legal authority to act on behalf of another individual regarding decisions relating to health care.

I understand that this authorization will expire:

☐ On _____ (MM/DD/YYYY) or one year from the date of the signature below (or as set forth by other applicable federal or state law)

OR

☒ Once the following event occurs:

Member's return to work

Form must be completed before signing

Signature of Member
or Member's Personal Representative

Date

Print Name of Member's
Personal Representative

Description of Personal Representative's
Authority to Act for Individual

Signature of Witness

Date

I understand that I am entitled to a copy of my signed authorization.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION



SEAP Excuse for Absence - Initial Clinical Review

The individual can be excused from work due to mental health reasons that impair the individual to the extent that you, the clinician, make a clinical recommendation that the individual be away from work. Please provide the following information to substantiate this individual's Excuse for Absence from the workplace. The EFA will not be considered without this documentation provided in a timely manner.

The form must be completed and returned to us by a **licensed mental health provider**. The case will be reviewed every two weeks until the individual is ready to return-to-work. A review date will provided once the EFA is processed by SEAP. Please plan to complete the Excuse for Absence Clinical Update Form and send to SEAP every two weeks.

Please send this completed form (with the ROI signed by the individual) to the SEAP Management Consultant Team at SEAP@optum.com or by fax at 866-340-5325. If you have additional questions, you may contact the SEAP Management Consultant Team by email at SEAP@optum.com or by calling 800-692-7459.

Client Name, DOB, Mbr ID/SS#:

Start date of absence from work:

Date(s) that Client has been seen by Clinician:

Presenting Issue and Clinical Symptoms:

Diagnosis:

Treatment plan (including frequency of appointments):

Justification for why employee cannot be at work:

Estimated time away from work:

Return to work date (if unknown, please write TBD):


Clinician Printed Name: _____ Date: _____

Clinician Signature: _____ Clinician Tax ID # _____
or Last 4 of SSN

Clinician Phone Number: _____

Clinician Email/Fax: _____

Preferred Contact Method: _____ Email _____ Fax _____ Phone



SEAP Excuse for Absence - Clinical Review Update

The individual can be excused from work due to mental health reasons that impair the individual to the extent that you, the clinician, make a clinical recommendation that the individual be away from work. Please provide the following information to substantiate this individual's Excuse for Absence from the workplace. The EFA will not be considered without this documentation provided in a timely manner.

The form must be completed and returned to us by a licensed mental health provider. The case will be reviewed every two weeks until the individual is ready to return-to-work. A review date will be provided once the EFA is processed by SEAP. Please plan to complete the Excuse for Absence Clinical Update Form and send to SEAP every two weeks.

Please send the completed form (with the ROI signed by the individual) to the SEAP Management Consultant Team at SEAP@optum.com or by fax at 866-340-5325. If you have additional questions, you may contact the SEAP Management Consultant Team by email at SEAP@optum.com or by calling 800-692-7459.

Client Name, Date of Birth, Member ID/SS#:	
Date(s) that Client has been seen by Clinician:	
Treatment Progress:	
Return to work date (if unknown, please write TBD):	Next appointment date:

Clinician Printed Name: _____

Date: _____

Clinician Signature: _____

Clinician Tax ID # _____
or Last 4 of SSN

Clinician Phone Number: _____

Preferred Contact Method:

Clinician Fax Number: _____

____ Phone ____ Email ____ Fax

Clinician Email Address: _____