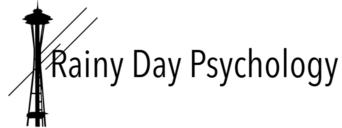

SERVICE REFERRAL FORM

Washington State Labor & Industries Claim

P: (253) 271-8079 | F: (253) 541-2446 | admin@rainydaypsychology.com

CLAIM INFORMATION

Claim Number: ____________ Date of Injury: ____________ Date of Referral: ____________

PATIENT INFORMATION

Patient Name: ____________________________________ Date of Birth: _________

Phone (Primary):________________________ Phone (Secondary): ________________________

Email:____

Preferred Contact Method: ☐Phone ☐Email ☐Mail ☐Interpreter needed - Language: ____________

CLAIMS MANAGER INFORMATION

Name: ____________________________________ Phone: ________________________

Email: ____________________________________ Fax: ___________________________

REFERRING PROVIDER INFORMATION

Provider Name: ________________________ Phone: ________________________

Clinic/Practice: ________________________ Fax: ___________________________

INJURY & DIAGNOSIS INFORMATION

Body Part(s) Injured: ____

Primary Diagnosis/ICD-10: ____

Accepted Conditions: ____

MH condition ever accepted/denied on claim? ☐ No ☐ Accepted: _________

☐ Denied: _________ ☐ Unknown

REASON FOR REFERRAL

☐ **BHI PATHWAY** — *recovery barriers; no MH condition on claim; no PA required*

☐ Pain coping/fear-avoidance ☐ Sleep issues ☐ Treatment engagement ☐ Return-to-work

☐ **MENTAL HEALTH PATHWAY** — *suspected/accepted MH condition; PA required*

☐ Depression/Anxiety ☐ PTSD ☐ Coping skills/Adjustment ☐ SUD ☐ Other: ____________

Service requested: ☐ Consultation only (90791) ☐ Eval & ongoing treatment

Additional clinical information/specific concerns:

AUTHORIZATION STATUS

☐Authorization Approved ☐Authorization Pending ☐No Authorization yet ☐N/A: BHI (No PA Req)

Auth Number (if applicable): ____________ Authorized Sessions: ____________

For Office Use Only: Date Received:___________ | Initial Contact Date:___________