Submit this document to:
Crime Victims Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP PROGRESS NOTE: FORM III

This form must be submitted to request preauthorization for payment of additional sessions. Preauthorization is contingent on the detail provided. You should begin to consider whether or not you will need more sessions, and the rational behind the need.

Bill Procedure Code 0124C For This Report.

Victim's Name		CVCP Claim Number
Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim)		Date Treatment Began
Time Period this Report Covers (*from* month/day/year *to* month/day/year)		Date Form Completed
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
Street City		State Zip+4

Does your patient have insurance other than CVCP? If so what insurance is available_____
It is your responsibility to verify your patient's insurance coverage and ensure its rules are being followed.

Please review the CVCP guidelines on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) Is there substantial progress toward recovery from the crime related condition(s)?
- ☐ Yes (continue on to question #2)
- ☐ No (continue on to question #3)

2) If yes, when do you expect treatment will be completed?

_____

3) What complicating or confounding issues are hindering recovery?