Washington State Department of Labor & Industries

Behavioral Health Interventions

State Fund Claim
PO Box 44291
Olympia WA 98504-4291
Fax to Claim file: 360-902-4567

BHI Individual Therapy: visit number _____ of 16
BHI Group Therapy: visit number _____ of 16
BHI Group – Number of people treated: _____

Billing Codes available here

Purpose of today's visit:

☐ Assessment ☐ Reassessment ☐ Intervention

Section 1: Demographics

Worker's Name	Claim Number
Provider Name	Provider ID Number
Face to face time (list times as specific and not ranges)	Date of Injury / Date of visit
Location/Setting	
Attending Provider Name	

Section 2: Intake and History

Goal for Attending Provider Referral and Worker Concerns:

Psychometric Measures:

PHQ-4 _____

GCPS Scores Item #1 _____ Item #2 _____

Outside of the treatment sessions with the worker, indicate which providers/L&I resources you will coordinate with to progress treatment goals:

☐ Claim Manager ☐ Activity Coach ☐ Attending Provider
☐ Physical Rehabilitation Provider ☐ Vocational Rehabilitation Provider
☐ Other: _____

What are the barriers, challenges, and experiences you are addressing with the worker to support recovery? Describe all that apply.
(e.g., interpersonal relationships, support systems, social isolation, unclear return to work expectations/plans, unclear claims process, catastrophizing, fear avoidance, perceived injustice, recovery expectations, substance abuse)

RESET

Worker's Name	Claim Number

Section 3: Goals

Describe mutually agreed upon treatment goals and specific behavioral interventions/modalities	**Estimated date of completion**
Treatment goal and behavioral interventions/modalities	
Treatment goal and behavioral interventions/modalities	
Treatment goal and behavioral interventions/modalities	
Treatment goal and behavioral interventions/modalities	
Treatment goal and behavioral interventions/modalities	

Note to claim manager and other providers (e.g., next steps, discharged successfully, opportunity for collaboration, return-to-work coordination, etc.):

Therapist's Name	Therapist's Phone Number
Therapist's Signature	Date Signed

Complete all sections. This form must be sent to the Department of Labor and Industries **AND** the Attending Provider.

Date sent to the Attending Provider: _____