Work Injury Network for Rapid Recovery

Workers' Compensation Tele-Behavioral Health

Email: **Referrals@WINRapidRecovery.com** Fax: **720-504-0095**

Patient Name ______________________ **Phone** ______________________

Patient Email ______________________ **Preferred Language** ◯ English ◯ Spanish

Your patient is a candidate for WIN Rapid Recovery tele-behavioral services for their musculoskeletal (MSK) injury if:

- There is reason to believe that a biopsychosocial factor or distress may be affecting the treatment or medical management of a MSK injury, and
- There is a documented need (outcome assessment) for psychological/behavioral services to successfully manage the functional impairment/MSK injury.

WIN Rapid Recovery also offers these services for your patients who have an underlying MSK injury:

- **Causality Assessment/Work Relatedness** – there are concerns regarding work relatedness and the need for behavioral health services given the mechanism of injury.
- **Pain Psychological Evaluation** – there are concerns regarding a poor response to current treatment(s).
- **Pre-Surgical Evaluation** – there is a need to assess potential post-procedure outcomes.

Orders (check all that apply):

◯ Consult: Initial Evaluation
◯ Consult and Treat: Initial Evaluation and 12 Follow-up Sessions
◯ Treat based on another psychologist's initial evaluation and recommendation for CBT (#) ________ Follow-up Sessions

◯ Causality Assessment/Work Relatedness
◯ Pain Psychological Evaluation
◯ Pre-Surgical Evaluation

WIN will request authorization for services.
If your office requests authorization, please use Evaluation codes 90791, 96130, and 96136 and Treatment code 90837.

Please send evaluation/progress notes to:

◯ Referring Provider
◯ Referral Contact
◯ Other ______________________

◯ By Secure (Zix) Email (enter at bottom of form)
◯ By Fax (enter at bottom of form)
◯ ______________________

Diagnoses ______________ ______________ ______________

Notes

Clinic ______________________

Referral Contact ______________________ **Email** ______________________

Phone ______________________ **Fax** ______________________

Provider Name ______________________ **NPI** ______________________

Signature ______________________

Include demographics with adjuster contact & claim number, H&P, most recent office visit note, and outcomes report (if any)