

Request for Authorization — Psychological Testing

Behavioral health services telephone: 1-800-454-3730/fax: 1-800-505-1193

General information

Member name:	DOB:	Age:	Member ID:
Name of psychologist:		Address:	
Provider #:		Provider NPI:	
Provider phone #:		Provider fax #:	
Provider email:			

Formal psychological testing is neither clinically indicated for routine screening/assessment of behavioral health disorders nor indicated for the administration of brief behavior rating scales and inventories. Such scales and inventories are an expected part of a routine and complete diagnostic process. Other than in exceptional cases, a diagnostic interview and relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization. Requests for placement purposes, disability evaluations and forensic purposes are not covered benefits. Requests for educational testing or educational assessment for learning disabilities should be referred to the public school system. **This form is for psychological testing requests only. Requests for neuropsychological or autism testing need to be completed on their requisite forms.**

Clinical assessment: Indicate which of the following assessments were completed.

<input type="checkbox"/> Psychiatric and medical history	<input type="checkbox"/> Clinical interview with patient	<input type="checkbox"/> Structured developmental and social history	<input type="checkbox"/> Medical evaluation	<input type="checkbox"/> Consultation with school or other important persons	<input type="checkbox"/> Direct observation of parent-child interactions
<input type="checkbox"/> Interview with family members	<input type="checkbox"/> Consultation with patient's physician	<input type="checkbox"/> Brief inventories and/or rating scales	<input type="checkbox"/> Review of medical records	<input type="checkbox"/> Review of academic records/IEP	<input type="checkbox"/> Family history pertinent to testing request

Please include any relevant clinical/medical records to support the testing request.
Clinical information: Indicate the presenting problems, symptoms and need for testing.

<input type="checkbox"/> Inattention	<input type="checkbox"/> Irritability	<input type="checkbox"/> Disorganization	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Labile mood	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Low motivation	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Poor attention span	<input type="checkbox"/> Acting out behavior	<input type="checkbox"/> Attention seeking	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions
<input type="checkbox"/> Low frustration tolerance	<input type="checkbox"/> Suicidal/homicidal ideation	<input type="checkbox"/> Violence/physical aggression	<input type="checkbox"/> Speech and language delays	<input type="checkbox"/> Other developmental delays
<input type="checkbox"/> Other:				
Duration of symptoms: <input type="checkbox"/> 0-3 months (MO) <input type="checkbox"/> 3-6 MO <input type="checkbox"/> 6-9 MO <input type="checkbox"/> 9-12 MO <input type="checkbox"/> > 12 MO				

Date of diagnostic interview: _____

Rating scales: Please indicate which rating scales have been administered as part of your clinical assessment (**prior to submitting the testing request**).

<input type="checkbox"/> BASC	<input type="checkbox"/> TSCC	<input type="checkbox"/> CDI	<input type="checkbox"/> STAI	<input type="checkbox"/> BDI
<input type="checkbox"/> Conner's	<input type="checkbox"/> Achenbach	<input type="checkbox"/> Brief	<input type="checkbox"/> MDQ	<input type="checkbox"/> BAI
<input type="checkbox"/> RAD	<input type="checkbox"/> CBCL	<input type="checkbox"/> MASC	<input type="checkbox"/> ADHD rating	<input type="checkbox"/> PCL-5
<input type="checkbox"/> Other:				

Treatment history: Please provide information regarding treatment history.

	How often does the member receive services (weekly, biweekly or monthly)?	How long has the member been in treatment?	Is the member still in treatment?	Have the member's symptoms improved?
Individual therapy				
Medication management				
School/home-based therapy				
Other services				

Other pertinent information
Please include any other information that supports the request for psychological testing:
Previous psychological testing
Please include any information regarding previous psychological testing (e.g., dates of testing or results) and why retesting is requested:
DSM-5/ICD-10 diagnosis
Rationale for testing
Please describe the rationale for testing. What are the current questions to be answered that cannot be addressed by the clinical interview or review of records and rating scales that you have already administered? How will the results of testing impact the course of treatment?
Is this a request for a trauma assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Psychological tests requested
Please list the tests you are requesting and the administration time. For tests with multiple versions, specify which one. If you are administering selected subtests, please indicate which ones. Please attach a separate sheet if necessary.
Please provide the hours and billing codes requested for the current psychological assessment:
96101 ____ hours (HRS) 96102 ____ HRS 96103 ____ HRS Other: ____ Total time requested in HRS: _____

Provider signature: _____ Date: _____

Note: We are unable to process illegible or incomplete requests.