AMERIGROUP IOWA, INC. PSYCHOLOGICAL TESTING REQUEST FOR AUTHORIZATION

Amerigroup Behavioral Health Services

Telephone: 1-800-454-3730 Fax: 1-866-877-5229

General information

Member name:	**Date of birth:**	**Amerigroup member ID:**	
Psychologist name:	**Amerigroup provider ID:**	**Phone:** **Fax:**	**Email:**

Formal psychological testing is neither clinically indicated for routine screening/assessment of behavioral health disorders nor is psychological testing 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 and forensic purposes are not covered benefits. Requests for educational testing or learning disabilities assessment for educational purposes should be referred to the public school system.

Clinical assessment

Indicate which of the following assessments have been completed:

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

Clinical information

Indicate presenting problems or symptoms, indicating need for testing**:**

☐ Inattention	☐ Irritability	☐ Disorganization	☐ Depression	☐ Anxiety
☐ Labile mood	☐ Lethargy	☐ Low motivation	☐ Distractibility	☐ Impulsivity
☐ Poor attention span	☐ Acting out behavior	☐ Attention seeking	☐ Hallucinations	☐ Delusions
☐ Low frustration tolerance	☐ Suicidal/ homicidal ideation	☐ Violence/physical aggression	☐ Speech and language delays	☐ Other developmental delays
☐ Other:				
Duration of symptoms: ☐ 0-3 Mo. ☐ 3-6 Mo. ☐ 6-9 Mo. ☐ 9-12 Mo. ☐ >12 Mo.				

Treatment history

Please provide information regarding treatment history:

	Frequency	Duration of treatment?	Is member still in treatment?	Have symptons improved?
Individual therapy:				
Medication management:				
School/home based tx:				
Other services:				

Date of diagnostic interview: _____

Rating scales

Please indicate which rating scales have been administered as part of your clinical assessment:

☐ BASC	☐ TSCC	☐ CDI	☐ STAI	☐ BDI
☐ Conner's	☐ Achenbach	☐ Brief	☐ MDQ	☐ BAI
☐ RAD	☐ CBCL	☐ MASC	☐ ADHD rating	☐ PCL-5
☐ Other:				
Please include any pertinent results of rating scales:				

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 and results) and why retesting is requested:

DSM-5/ICD-10 diagnoses

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, 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? ☐ Yes ☐ No

Psychological tests requested

Please list the tests you are requesting and the administration time:

Total time requested in hours:

Provider signature: _____ Date: _____

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