



SUBMIT TO:
Utilization Management Department
PHONE 1.877.647.4848 FAX 1.866.694.3649

PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM

*All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.

IDENTIFYING INFORMATION

Member Name _____ DOB _____ SSN _____
Member ID # _____ Health Plan Name _____
Provider Name _____ OR Agency/Group Name _____
Professional Credentials _____
Provider Phone # _____ Fax # _____
Address (street/city/state) _____
NPI # _____ Tax ID # _____
Referral Source _____

DIAGNOSIS (PLEASE REPORT ALL DIAGNOSES BEING CONSIDERED FOR THIS MEMBER)

Primary (Required) _____ R/O _____ R/O _____
Secondary _____
Tertiary _____
Additional _____
Additional _____
Danger to Self or Others (If yes, please explain)? [] Yes [] No _____
MSE Within Normal Limits (If no, please explain)? [] Yes [] No _____

WHAT ARE THE CURRENT SYMPTOMS PROMPTING THE REQUEST FOR TESTING?

- [] Anxiety [] Psychosis/Hallucinations [] Eating disorder symptoms [] Inattention
[] Depression [] Inexplicable Behavior [] Poor academic performance [] Hyperactivity
[] Withdrawn/poor social interaction [] Unprovoked agitation/agression [] Behavior problems at home [] Other
[] Mood instability [] Self-injurious Behavior [] Behavior problems at school _____

What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing affect the care and treatment in a meaningful way?

MEMBER HISTORY

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Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past? Yes No

Comments _____

Does the patient have a family history of psychiatric disorders, behavior problems or substance use? Yes No Uncertain

Comments _____

Is there any known or suspected history of physical or sexual abuse or neglect? Yes No Uncertain

Comments _____

If ADHD is a diagnostic rule out, please complete the following: Is the patient's presentation on intake consistent with ADHD? Yes No

Indicate the results of Conner's or similar ADHS rating scales, if given: Positive Negative Inconclusive N/A

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (i.e., teacher feedback, results of school standardized testing) _____

Date of Diagnostic Interview _____

Has the patient had a Psychiatric Evaluation? Yes No If yes, date of the interview _____

Previous Psychological Testing? Yes No If yes, date? _____

Basic Focus and Results _____

CURRENT PSYCHOTROPIC MEDICATIONS

Prescriber: Psychiatrist General Practitioner Other

Medication Name	Date Started	Compliant? (Y/N)

REQUEST FOR AUTHORIZATION

Please check only one code:

Psych Testing

NeuroPsych Testing

Developmental Testing

Please list the tests planned to answer the clinical questions.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Number of units requested to complete tests: _____

Provider Name _____

Provider Signature _____ Date _____

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).