SUBMIT TO
Utilization Management Department
PHONE 1.877.647.4848 | FAX 1.866.694.3649

PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date_____

MEMBER INFORMATION

Name _____

Date of Birth_____

Member ID #_____

Health Plan _____

PROVIDER INFORMATION

Provider Name _____

Provider Tax ID# _____

Provider NPI/Sub Provider #_____

Phone_____Fax _____

Address _____

CURRENT ICD DIAGNOSIS

The provider must report all diagnoses being considered for this patient.

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
☐ Depression
☐ Withdrawn/Poor social interaction
☐ Mood instability
☐ Psychosis/Hallucinations
☐ Bizarre behavior
☐ Unprovoked agitation/Aggression
☐ Self-injurious behavior
☐ Eating disorder symptoms: _____
☐ Poor academic performance
☐ Behavior problems at home
☐ Behavior problems at school
☐ Inattention
☐ Hyperactivity
☐ Other _____
_____
_____

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?

0618.CP.P.FO.1 6/18

HISTORY

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 ADHD 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? _____

Basic Focus and Results_____

CURRENT PSYCHOTROPIC MEDICATIONS

Prescriber: ☐ Psychiatrist ☐ General Practitioner ☐ Other

MEDICATION	DATE STARTED	COMPLIANT? (Y/N)

REQUEST FOR AUTHORIZATION

Please check only one code:

Psych Testing:
- ☐ 96101
- ☐ 96102
- ☐ 96103
- ☐ 96105
- ☐ 96110
- ☐ 96111

Neruo Psych Testing:
- ☐ 96116
- ☐ 96118
- ☐ 96119

Please list the tests planned to answer the clinical questions.

1._____
2._____
3._____
4._____
5._____
6._____

Number of units requested to complete tests: _____

STANDARD REVIEW:
Standard 14-day time frame will be applied.

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Clinician Signature_____ Date _____ Clinician Signature_____ Date _____

Clinician Name _____ Clinician Name _____