**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| □ Withdrawn/poor social interaction | □ Unprovoked agitation/agression | □ Behavior problems at home | □ Other |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.).