



SUBMIT TO:  
**Utilization Management Department**  
 PHONE 1-855-735-4398 FAX 1-877-725-7751

## PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM

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

Please indicate which level of care the member is currently engaged: \_\_\_\_\_ Inpatient \_\_\_\_\_ Outpatient

### PATIENT INFORMATION

### PROVIDER INFORMATION

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Member ID #: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Health Plan Name: \_\_\_\_\_  
 Referral Source: \_\_\_\_\_

Provider/Agency Group Name: \_\_\_\_\_  
 Professional Credentials: \_\_\_\_\_  
 Provider Tax ID#: \_\_\_\_\_  
 Provider NPI/Sub Provider #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### CURRENT ICD DIAGNOSIS

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

\*Primary: \_\_\_\_\_ 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?

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Anxiety                           | <input type="checkbox"/> Self-injurious Behavior         | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Eating disorder symptoms: _____ | _____                                |
| <input type="checkbox"/> Withdrawn/poor social interaction | <input type="checkbox"/> Poor academic performance       | _____                                |
| <input type="checkbox"/> Mood instability                  | <input type="checkbox"/> Behavior problems at home       |                                      |
| <input type="checkbox"/> Psychosis/Hallucinations          | <input type="checkbox"/> Behavior problems at school     |                                      |
| <input type="checkbox"/> Bizarre Behavior                  | <input type="checkbox"/> Inattention                     |                                      |
| <input type="checkbox"/> Unprovoked agitation/aggression   | <input type="checkbox"/> Hyperactivity                   |                                      |

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?

**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  
\_\_\_\_\_

NeuroPsych Testing  
\_\_\_\_\_

Please list the tests planned to answer the clinical questions.

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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: \_\_\_\_\_

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Have any questions?  
Call us at 1-855-735-4398