wellcare PRIME by absolute total care | Healthy Connections PRIME

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

Name: _____

Date of Birth:_____

Member ID #: _____

Social Security #:_____

Health Plan Name: _____

Referral Source: _____

PROVIDER INFORMATION

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?

☐ 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☐ Withdrawn/poor social interaction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?

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

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.

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

Number of units requested to complete tests: _____

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

Clinician Signature:_____Date: _____

Clinician Name:_____

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 Name: _____

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12515-8 Research Blvd., Suite 400
Austin, Texas 78759
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mmp.absolutetotalcare.com