

OUTPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

Date _____

PATIENT INFORMATION

PROVIDER INFORMATION

Name _____

Provider Name _____

Date of Birth _____

Group Name _____

Patient ID # _____

Provider NPI/TIN # _____

Referral Source _____

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 Withdrawn/poor social interaction | 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 disorder?

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 test)? _____

Date of Diagnostic Interview: _____

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

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

Basic Focus and Results _____

Current Psychotropic Medications: _____

PLEASE LIST THE TESTS PLANNED TO ANSWER THE CLINICAL QUESTION(S)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

PLEASE INDICATE THE NUMBER OF UNITS REQUESTED TO COMPLETE TESTS:

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

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

SUBMIT TO
Utilization Management Department
PHONE: 1.800.589.3186
FAX 1.866.694.3649