

SUBMIT TO

Utilization Management Department

Phone: 1-877-644-4623 Fax: 1-844-824-7705



OUTPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

MEMBER INFORMATION

Name _____

Date of Birth _____

Member ID # _____

SSN # _____

Health Plan _____

PROVIDER INFORMATION

Provider Name _____

Group Name _____

Provider Tax ID# _____ NPI/# _____

Phone _____ Fax _____

Referral Source _____

PROVISIONAL DSM-IV 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- Withdrawn/poor social interaction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
- Poor academic performance
- Behavior problems at home
- Behavior problems at school
- Inattention
- Hyperactivity
- Eating disorder symptoms: _____
- 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?

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

Date of Diagnostic Interview _____

Has the patient had a Psychiatric Evaluation? 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

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