sunflower health plan

Medicaid | Marketplace | Medicare

Sunflower Product Line:

- ☐ KanCare (Medicaid)
- ☐ Ambetter (Health Insurance Marketplace)
- ☐ Wellcare By Allwell (Medicare Advantage)

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.

PATIENT INFORMATION

Name _____

Date of Birth _____

Member ID# _____

Social Security # _____

Health Plan # _____

PROVIDER INFORMATION

Provider Name _____

Group Name _____

Provider Tax ID# _____ NPI# _____

Fax# _____ Phone# _____

Referral Source _____

PROVISIONAL DSM-V DIAGNOSIS

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

Primary _____ R/O _____ R/O _____

Secondary _____

RATIONALE

1. Describe the clinical rationale for this testing request. Choose all that apply:
   - ☐ Psychiatric disorder evident but uncertainty about differential diagnosis
   - ☐ Lack of expected progress in evidence-based psychiatric or psychological treatment
   - ☐ Seizures with suspected psychogenic etiology
   - ☐ Screening prior to a medical or surgical intervention
   - ☐ Behavioral prediction for judicial or correctional purposes
   - ☐ Detection of malingering or disability adjudication or forensic purposes
   - ☐ Other, please describe _____
2. All assessment activities have failed to answer the above clinical question ☐ Yes ☐ No
3. Is there a psych testing plan in place? ☐ Yes ☐ No
4. Is the member experiencing functional impairment or reporting internal distress? ☐ Yes ☐ No
5. What action will be taken/how will treatment plan be affected by the test? _____
6. Does the patient have the cognitive and language skills required for the proposed test? ☐ Yes ☐ No
7. Are there any existing medical conditions, substance use, psychotic features or recent trauma that would contraindicate testing?
   ☐ Yes ☐ No Details: _____
8. Have behavioral disturbances been suspected or confirmed? ☐ Yes ☐ No Details: _____

PATIENT HISTORY

1. Has the patient psychiatric and medical history obtained? ☐ Yes ☐ No
2. Has the patient's family psychiatric and medical history been explored? ☐ Yes ☐ No
3. Has information from current or former behavioral health evaluations or testing or treatment providers been collected? Please select one:
   - ☐ Records have been reviewed from previous treatment or psychological testing information or a consult has taken place with previous or current service provider(s)
   - ☐ Unable to obtain this information, despite two attempts
   - ☐ No other psychiatric or substance-use services provided to patient within last two years
   - ☐ Other, please describe _____
4. Has collateral information from significant other or family members who live with patient been collected? Choose one:
   - ☐ Interviewed at least one family member or parent or guardian if under 18
   - ☐ All other adults in the home contacted and each refuses to participate
   - ☐ Contact with any other adult in the home contraindicated because abuse by family member suspected or confirmed
   - ☐ Patient does not live with significant other or any adult family members
   - ☐ Contact with any other adult in the home contraindicated because family member cognitive impaired due to medical condition or persistent substance abuse dementia
   - ☐ Patient refuses to allow significant other or family member involvement due to profound distrust or paranoia
   - ☐ Other, please describe _____

ASSESSMENTS

1. Has there been at least one validated symptom inventory or rating scale administered to patient or caregiver? ☐ Yes ☐ No
2. A clinical interview has been performed on the patient ☐ Yes ☐ No
3. Has a structured or semi-structured interview been performed? Choose all that apply:

(17 and under)

- ☐ Children's Interview for Psychiatric Syndromes (ChiPS) Children and Parent (P-ChiPS) Versions
- ☐ Diagnostic Interview Schedule for Children (DISC)
- ☐ Mini-international neurological interview for Children and Adolescents (MINI-KID)
- ☐ Anxiety Disorders Interview Schedule for Children (ADIS) Child and Parent Interview Schedules
- ☐ Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS)
- ☐ Other, please describe _____

(18 and over)

- ☐ Structured clinical interview for DSM disorders (SCID) performed
- ☐ Diagnostic Interview Schedule for Children (DISC)
- ☐ Mini-international neurological interview (MINI)
- ☐ Schedule for Affective Disorders and Schizophrenia (SADS)
- ☐ Other, please describe _____

_____

4. Has a medical evaluation been performed since onset of symptoms to rule out medical causes? ☐ Yes ☐ No

If member is under 18, please answer the following question

5. Have any of the following assessments been performed? Choose all that apply:
   - ☐ Validated rating scale completed by teachers
   - ☐ Consultation with school personnel or other important persons in patient life
   - ☐ Direct observation of parent-child interactions or child in natural settings
   - ☐ Other, please describe _____

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

1.	**2.**
3.	**4.**
5.	**6.**

SERVICES REQUESTED

CODE REQUESTED	UNITS REQUESTED	TIME FRAME REQUESTED
Test evaluation:		
96130 (first hr)		
96131 (each additional hour)		
Test administration and scoring:		
96136 (first 30 min)		
96137 (each additional 30 min)		
96138 (first 30 min)		
96139 (additional 30 min)		
Automated testing and Result:		
96146		

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.

Clinician Signature Date

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

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