



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

PROVIDER INFORMATION

Name
Date of Birth
Member ID#
Social Security #
Health Plan #

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
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
Other, please describe
Screening prior to a medical or surgical intervention
Behavioral prediction for judicial or correctional purposes
Detection of malingering or disability adjudication or forensic purposes
2. All assessment activities have failed to answer the above clinical question
3. Is there a psych testing plan in place?
4. Is the member experiencing functional impairment or reporting internal distress?
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?
7. Are there any existing medical conditions, substance use, psychotic features or recent trauma that would contraindicate testing?
8. Have behavioral disturbances been suspected or confirmed?

PATIENT HISTORY

- 1. Has the patient psychiatric and medical history obtained?
2. Has the patient's family psychiatric and medical history been explored?
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 refuses to allow significant other or family member involvement due to profound distrust or paranoia
Patient does not live with significant other or any adult family members
Other, please describe

ASSESSMENTS

- Has there been at least one validated symptom inventory or rating scale administered to patient or caregiver? Yes No
- A clinical interview has been performed on the patient Yes No
- 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 _____

- 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

- 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 _____

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.

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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