



**SUBMIT TO:**  
**Utilization Management Department**  
 PHONE 1.877.647.4848 FAX 1.866.694.3649

**PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM**

**\*All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.**

**IDENTIFYING INFORMATION**

Member Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
 Member ID # \_\_\_\_\_ Health Plan Name \_\_\_\_\_  
 Provider Name \_\_\_\_\_ OR Agency/Group Name \_\_\_\_\_  
 Professional Credentials \_\_\_\_\_  
 Provider Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Address (street/city/state) \_\_\_\_\_  
 NPI # \_\_\_\_\_ Tax ID # \_\_\_\_\_  
 Referral Source \_\_\_\_\_

**DIAGNOSIS (PLEASE REPORT ALL DIAGNOSES BEING CONSIDERED FOR THIS MEMBER)**

Primary (Required) \_\_\_\_\_ 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"/> Psychosis/Hallucinations	<input type="checkbox"/> Eating disorder symptoms	<input type="checkbox"/> Inattention
<input type="checkbox"/> Depression	<input type="checkbox"/> Inexplicable Behavior	<input type="checkbox"/> Poor academic performance	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Withdrawn/poor social interaction	<input type="checkbox"/> Unprovoked agitation/aggression	<input type="checkbox"/> Behavior problems at home	<input type="checkbox"/> Other
<input type="checkbox"/> Mood instability	<input type="checkbox"/> Self-injurious Behavior	<input type="checkbox"/> Behavior problems at school	_____

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?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEMBER HISTORY**

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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 ADHS 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 of the interview \_\_\_\_\_

Previous Psychological Testing?  Yes  No If yes, date? \_\_\_\_\_

Basic Focus and Results \_\_\_\_\_

**CURRENT PSYCHOTROPIC MEDICATIONS**

Prescriber:  Psychiatrist  General Practitioner  Other

Medication Name	Date Started	Compliant? (Y/N)

**REQUEST FOR AUTHORIZATION**

Please check only one code:

Psych Testing

\_\_\_\_\_

\_\_\_\_\_

NeuroPsych Testing

\_\_\_\_\_

\_\_\_\_\_

Developmental Testing

\_\_\_\_\_

\_\_\_\_\_

Please list the tests planned to answer the clinical questions.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

Number of units requested to complete tests: \_\_\_\_\_

Provider Name \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

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