



SUBMIT TO:
Utilization Management Department
 12515-8 Research Blvd., Suite 400
 Austin, Texas 78759
 PHONE 1.877.687.1169
 FAX 1.855.279.6165

PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM

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

Please indicate which level of care the member is currently engaged: INPATIENT OUTPATIENT

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 Withdrawn/poor social interaction	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/agression	<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

SUBMIT TO:
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE 1.877.687.1169
FAX 1.855.279.6165

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:

96101 96102 96103

NeuroPsych Testing:

96116 96118 96119 96120

Aphasia Assessment: 96105

Developmental Testing:

96110 96111 96125

Please list the tests planned to answer the clinical questions.

- _____
- _____
- _____
- _____
- _____
- _____

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.).