PSYCHOLOGICAL TESTING PRE-AUTHORIZATION REQUEST FORM*
BEHAVIORAL HEALTH SERVICES

Please fax to: Behavioral Health Unit Toll Free: 1.866.616.6255

*****All sections must be completed for timely pre-authorization consideration.*

Today's Date:	Member's ID#:
Member's Name:	Date of Birth:

Referring Provider:	Phone Number:
Address:	

Testing Provider:	Phone Number:
Address:	

Has a diagnostic interview been conducted by the requesting practitioner? ☐ Yes ☐ No

Date of review? _____ Was rating scales and/or inventories completed? ☐ Yes ☐ No

If so, please list:

DIAGNOSIS CODES	
CODE	
1)	
2)	
3)	
4)	

CPT	
TESTS REQUESTED	HOURS

INFORMATION CONTINUED for Member: _____

WHAT IS SPECIFIC QUESTION(S) TO BE ANSWERED BY TESTING?

Is testing related to the diagnosis of ADHD? ☐ Yes ☐ No

If IQ testing is requested, please provide the reason for this testing.

WHAT ARE THE CURRENT SYMPTOMS THE CLIENT IS EXHIBITING?

HOW WILL THE RESULTS OF THE TESTING AFFECT THE TREATMENT PLAN?

WHAT TREATMENT(S) HAS/HAVE ALREADY BEEN RENDERED TO THE CLIENT?

ARE THERE ANY FACTORS THAT COULD AFFECT THE OUTCOME OF THE TEST (I.E. SUBSTANCE USE DISORDER, ILLITERATE)?

INFORMATION CONTINUED for Member: _____

WHAT IS TESTING PLAN:
Determine diagnosis? ☐ Yes ☐ No Lack of expected progress in treatment? ☐ Yes ☐ No

RELEVANT MEDICAL/PSYCHIATRIC HISTORY.

DESCRIBE ANY HISTORY OBTAINED FROM FAMILY/SCHOOL, SIGNIFICANT OTHERS.

DESCRIBE ANY HISTORY OBTAINED FROM CURRENT AND FORMER BH PROVIDERS OR TREATMENT.

IF UNABLE TO OBTAIN INFORMATION FROM FAMILY OR PROVIDERS, PLEASE EXPLAIN ATTEMPTS OR REASON.

_____ _____

Provider Signature Request Date

REVIEWED 08/23/2018