AmeriHealth Caritas District of Columbia

Psychological/Neuro-Psychological Testing Request

Please print clearly — incomplete or illegible forms will delay processing.

Member Information

Patient name: _____

Health plan: _____

DOB: _____

SS number: _____

Patient ID number: _____

Referral source: _____

Provider Information

(Please indicate by checking below whether requested services should be authorized to the provider or agency.)

☐ Provider

☐ Group/ Agency Name: _____

Professional Credential: ☐ MD ☐ PhD ☐ Other: _____

Physical Address:

Phone: Fax:

Medicaid/TPI/NPI number: Tax ID number:

Referral Reason/Question:

Testing will not be authorized under any of the following conditions:

1. Testing is primarily for educational or vocational purposes
2. Testing is primarily for legal purposes
3. The tests requested are experimental or have no documented validity
4. The time requested to administer the testing exceeds established time parameters
5. Testing is routine for entrance into a treatment program

Is this testing required for educational purposes, behavioral health purposes, or both? Explain:

State how the anticipated results of the testing will affect the patient's treatment plan:

DSM IV Axis

AXIS I	R/O	R/O
AXIS II		
AXIS III		
AXIS IV		
AXIS V	CURRENT	PAST YEAR

Danger to self or others? ☐ Yes ☐ No

If yes, please explain:

MSE within normal limits? ☐ Yes ☐ No

If no, please explain:

List Current Medications:

Name/Strength	Directions

What are the Current Symptoms Prompting the Request for Testing?

☐ Anxiety
☐ Depression
☐ Inattention
☐ Confusion
☐ Hypoactivity
☐ Hyperactivity
☐ Psychosis/hallucinations
☐ Bizarre behavior
☐ Unprovoked agitation/aggression
☐ Self-injurious behavior
☐ Eating disorder symptoms
☐ Withdrawn/poor social interaction
☐ Mood instability
☐ Changes in memory capacity
☐ Changes in cognitive capacity
☐ Behavior problems affecting life functions (e.g., school, home)
☐ Poor academic performance
☐ Other, list: _____

Comment/explain:

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Was a Behavioral Health Evaluation completed (e.g., 90801)?	History
☐ Yes ☐ No Date: _____ Results: _____ _____ Was previous psychological or neuro-psychological testing conducted? ☐ Yes ☐ No Date: _____ Basic focus and results: _____ _____	When was the patient's last physical examination? If ADHD is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available: ☐ Positive ☐ Negative ☐ Inconclusive ☐ Not applicable Comment/explain:

Start Date MM/DD/YY	Stop Date MM/DD/YY	CPT code	Modifier(s)	Units Requested

Please list the tests planned to answer the clinical questions:

Test	Reason for Use	Educational Yes/No	Number of Units Requested for Test	Number of Units Approved for Test

Indicate the total number of units (hours) requested:

Provider signature:

Date:

Submit to:
AmeriHealth Caritas D.C. Utilization Management
Fax: **1-855-410-6638**
For assistance please call **1-800-408-7510**.

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DHCF

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