

Psychological and Neuropsychological Testing Request

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

Member information	Provider information	
Patient name: _____	(Please indicate by checking below whether requested services should be authorized to the provider or agency.)	
Health plan: _____	<input type="checkbox"/> Provider	
Date of birth: _____	<input type="checkbox"/> Group or agency Name: _____	
Social Security number: _____	Professional credential: <input type="checkbox"/> M.D. <input type="checkbox"/> Ph.D. <input type="checkbox"/> Other: _____	
Patient ID number: _____	Physical address: _____	
Referral source: _____	Phone: _____ Fax: _____	
	Medicaid/TPI/NPI number: _____ Tax ID number: _____	
Referral reason or question:		
Testing will not be authorized under any of the following conditions:		
1. Testing is primarily for educational or vocational purposes 4. The time requested to administer the testing exceeds established time parameters 2. Testing is primarily for legal purposes 3. The tests requested are experimental or have no documented validity 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	What are the current symptoms prompting the request for testing?	
AXIS I R/O R/O	<input type="checkbox"/> Anxiety <input type="checkbox"/> Self-injurious behavior	
AXIS II	<input type="checkbox"/> Depression <input type="checkbox"/> Eating disorder symptoms	
AXIS III	<input type="checkbox"/> Inattention <input type="checkbox"/> Withdrawing or poor social interaction	
AXIS IV	<input type="checkbox"/> Confusion <input type="checkbox"/> Mood instability	
AXIS V CURRENT PAST YEAR	<input type="checkbox"/> Hypoactivity <input type="checkbox"/> Changes in memory capacity	
Danger to self or others? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hyperactivity <input type="checkbox"/> Changes in cognitive capacity	
If yes, please explain:	<input type="checkbox"/> Psychosis/hallucinations <input type="checkbox"/> Behavior problems affecting life functions (e.g., school, home)	
	<input type="checkbox"/> Bizarre behavior	
Mental status exam (MSE) within normal limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unprovoked agitation or aggression <input type="checkbox"/> Poor academic performance	
If no, please explain:	<input type="checkbox"/> Other, list: _____	
List current medications:		
Name and strength	Directions	Comments:

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Was a behavioral health evaluation completed (e.g., 90801)?	History
<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Results: _____ _____ Was previous psychological or neuropsychological testing conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Basic focus and results: _____ _____	When was the patient's last physical examination? If attention-deficit/hyperactivity disorder (ADHD) is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not applicable Comments: _____ _____

Start date MM/DD/YY	Stop date MM/DD/YY	CPT code	Modifiers	Units requested

Please list the tests planned to answer the clinical questions.				
Test	Reason for use	Educational (yes or 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 DC Utilization Management
 Fax: **1-855-410-6638**
 For assistance, please call **1-800-408-7510**.

