



SUBMIT TO:
Utilization Management Department
 5900 E. Ben White Blvd.
 Austin, Texas 78741
 PHONE: 1-877-687-1196
 FAX: 1-866-900-6918

PSYCHOLOGICAL OR NEUROPSYCH TESTING INPATIENT 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 Withdrawn/poor social interaction	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/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

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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:

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.

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.).