NETWORK HEALTH

Authorization Request for Psychological Testing Form

Fax to: 888-977-0776

Today's date ___ /___ /____

We've designed this form to help facilitate testing requests. We must preauthorize all psychological and/or neuropsychological testing requests. We will administratively deny services performed without prior authorization or authorization requests that occur beyond the testing date.

Member information *Please verify member's eligibility before rendering services.*

Member name ____________________ Member ID # ____________ DOB ___ /___ /___

Clinician requesting testing ____________________

Provider agency ____________________ Provider phone ____ - ____ - ____

Testing psychologist ____________________

NPI # ____________________

Network Health provider ID # or billing ID # ____________________ Tax ID # ____________

Testing agency ____________________ Agency phone ____ - ____ - ____

Presenting problem and reason for authorization request

List specific questions that testing will answer

Current symptoms/mental status *Please include mood disturbance, psychosis, suicidal/homicidal ideation, past/present physical and/or sexual abuse, and relational capacity.*

Academic issues

Was a case conference/CORE held at school? ☐ Y ☐ N If yes, when? ___ /___ /____

School name ____________________ District ____________________

Special education ☐ Y ☐ N Chapter 766 ☐ Y ☐ N IEP ☐ Y ☐ N

Dates of any previous psychological testing ____________________

Please summarize the results of previous psychological testing.

Member ID # ____________________

Medical issues *Please include any known pregnancy/birth complications, brain injury, head trauma, or lead poisoning.*

Date of last physical examination ___ /___ /___

Medications *(psychiatric or medical)*

History of substance use/abuse? ☐ Y ☐ N If yes, what substances? ____________________

Last use ___ /___ /___ Age at first use ____________________

List past/present mental health treatment and dates *(i.e., psychiatric hospitalizations, outpatient treatment)*

How will testing *directly* affect the treatment process? How will results influence treatment decisions, facilitate treatment goals, and/or provide information beyond what is currently available?

Diagnosis

Axis I ____________________ Axis II ____________________ Current GAF ____________________

Please mark the psychological/neuropsychological tests *Please specify specific intervention — not the modality of counseling.* ☐ 96101 Psychological testing ☐ 96118 Neuropsychological testing

If a licensed psychologist will conduct the test, please add appropriate modifier to CPT code. If a psychologist intern or Ph.D. (under the supervision of a licensed psychologist) will conduct the test, add appropriate modifier to CPT code.

Dates for which requested testing will occur ___ /___ /___ to ___ /___ /___

Tests to be administered

Number of hours requested _________

Best time and phone number to reach psychologist to provide authorization ____________________

Signature of clinician completing request ____________________ Date ___ /___ /___

For Network Health use only

Authorized dates to occur ___ /___ /___ to ___ /___ /___

Procedures and units authorized ____________________