

SUBMIT TO  
**Utilization Management Department**  
Phone: 1.866.864.1459 Fax: 1.866.694.3649



## OUTPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

Date \_\_\_\_\_

### MEMBER WINFORMATION

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Patient ID # \_\_\_\_\_

Referral Source \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name \_\_\_\_\_

Group Name \_\_\_\_\_

Provider NPI/TIN # \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### CURRENT ICD DIAGNOSIS

The provider must report all diagnoses being considered for this patient.

\*Primary \_\_\_\_\_ 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"/> Self-injurious Behavior         |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Eating disorder symptoms: _____ |
| <input type="checkbox"/> Withdrawn/poor social interaction | <input type="checkbox"/> Poor academic performance       |
| <input type="checkbox"/> Mood instability                  | <input type="checkbox"/> Behavior problems at home       |
| <input type="checkbox"/> Psychosis/Hallucinations          | <input type="checkbox"/> Behavior problems at school     |
| <input type="checkbox"/> Bizarre Behavior                  | <input type="checkbox"/> Inattention                     |
| <input type="checkbox"/> Unprovoked agitation/aggression   | <input type="checkbox"/> Hyperactivity                   |
|  | <input type="checkbox"/> Other _____                     |

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?

**HISTORY**

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures?

Yes  No Comments: \_\_\_\_\_

Does the patient have a family history of psychiatric disorders, behavior problems or substance use disorder?

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 ADHD 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 (ie.,teacher feedback, results of school standardized testing) ? \_\_\_\_\_

Date of Diagnostic Interview: \_\_\_\_\_

Has the patient had a Psychiatric Evaluation?  Yes  No If yes, date? \_\_\_\_\_

Previous Psychological Testing?  Yes  No If yes, date? \_\_\_\_\_

Basic Focus and Results \_\_\_\_\_

Current Psychotropic Medications: \_\_\_\_\_

**PLEASE LIST THE TESTS PLANNED TO ANSWER THE CLINICAL QUESTION(S)**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_
- 11. \_\_\_\_\_
- 12. \_\_\_\_\_

**PLEASE INDICATE THE NUMBER OF UNITS REQUESTED TO COMPLETE TESTS:**

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

\_\_\_\_\_  
Clinician Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

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