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REQUEST FOR PSYCHOLOGICAL TESTING

PLEASE TYPE ALL INFORMATION. NOTE THAT REQUEST WILL NOT BE ACCEPTED UNLESS COMPLETED IN DETAIL WITH ALL SUPPORTING INFORMATION ATTACHED.

Type of Service Requested: ☐ **Psychological Testing** ☐ **Neuropsychological Testing**
☐ **Psychosexual Testing** *(See bottom of last page for potentially authorized CPT codes and units.)*

Name: **DOB**: **AHCCCS** #:

Guardian: ☐ **Parent**: ☐ **DCS**:

Other Members of Team: ☐ **JPO** ☐ **DDD** ☐ **DCS** ☐ **Other**

Treating Doctor/NP Name : **Phone/Email**:

Clinic: **Phone/Email:**

Case Manager: **Phone/Email:**

Requesting Clinician/Title: **Phone/Email**:

Current location of member: (*i.e. inpatient, foster care, family, home*)

Diagnosis *including substance use /abuse/dependence: Please be detailed including developmental disability if applicable.*

Axis I:

Axis II:

Axis III:

What is the clinical question to be answer by testing?

Is this meant to support custody evaluations, parenting assessments, or court ordered testing? ☐ **Yes** ☐ **No**

Is this testing for Educational or Vocational purposes? ☐ **Yes** ☐ **No**

What are the current symptoms and/or functional impairments related to testing question?

How would the results of testing affect the treatment plan (please be specific)?

Medical/Psychological Evaluation and Treatment

Has patient had a psychiatric diagnostic evaluation? ☐ **Yes** **Date:** ☐ **No**

Has patient had previous psychological testing? ☐ **Yes** **Date:** ☐ **No**

Focus of prior evaluation:

If current request is ADHD related, indicate latest results of Conners' or similar ADHD ratings scales (please attach):
☐ **Positive** ☐ **Inconclusive** ☐ **Negative** ☐ **N/A (not ADHD related or no administration of rating scales.**

Is testing intended to diagnose Autism Spectrum disorders? ☐ **Yes** ☐ **No**

If Yes: *Attach detailed Psychiatric Evaluation which should include a review of records of pediatrician, PCP, school observations, coordination, rating scales and any other testing completed.*

Current Substance Use (please document all substance abuse within the last year):

Requesting Clinician Signature: _____ Date:

Supervisor Name Signature: _____ Date:

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Form Date: 03/22/2017

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Current Psychiatric Medication list with dosages and effect:

Name of Medication Dose Target Symptoms Effect/Duration of Trial/Compliance

THE FOLLOWING MUST BE COMPLETED BY PSYCHIATRIC PROVIDER OR MEDICAL DIRECTOR IF NOT ASSIGNED OR ASSIGNED PROVIDER IS NOT AVAILABLE.

Detailed Clinical summary from treatment psychiatric provider for 6 months:

Clinical opinion and rationale (based on criteria) of psychiatric provider for testing request:

Printed Name of Provider:

Phone: **Email:**

Signature of Provider: _____ Date:

Required Attachments:

- **BHMP Evaluation and progress notes that detail assessment of clinical concern listed above.**
- **Any supporting rating scales**
- **Neurological assessment, reviewed by BHMP if for a Neuropsychological Evaluation**
- **Any prior testing completed**

Psychological testing: 96101-, 96102 -, 96103 -
Neuropsychological testing: 96116, 96118, 96119
Psychosexual testing: 96101, 96102, 96103

Name of Identified Mercy Care Contracted Provider

Servicing Provider/Facility Information:

Servicing Provider Organization:

Address:

TIN#: **NPI#:** **Phone#:**

Administrative Contact Name:

Billing Address:

After this form is completed, please fax it to Mercy Care's Prior Authorization Department at 1-800-217-9345.