Psychological Testing Prior Authorization Request

Member Name: ______________________________ **DOB:** ______________

ID#: ______________________________ **INSURANCE:** ☐ CHIP ☐ STAR

Current Diagnoses under evaluation:
Axis 1 _________ **Axis 2** _________ **Axis 3** _________ **Axis 4** _________ **Axis 5** _________

1. **Brief psychiatric history of patient (including previous psychiatric admissions):**

2. **Describe the results of treatment to date and the reason testing is indicated at this time.**

3. **Have resources for psychological evaluation through the patient's school been explored?**

   ☐ YES ☐ NO Explain: ____

____

____

4. **Which area(s) most appropriately describe(s) the current questions to be addressed by testing?**

Clinical Questions	Specific Test(s) Planned	Tests Approved (Office Use Only)
a. Organic/neuro psychological factors related to disturbances in functioning	____________	____________
b. Learning disabilities	____________	____________
c. Disturbances in reality testing (psychosis)	____________	____________
d. Degree of Affective/behavioral disturbance manifested	____________	____________
e. Nature of personality structure	____________	____________

5. **Describe your treatment plan and how it is going to be affected by the results of the testing.**

____

____

____

Member Name: ____ DOB: __________________

6. Will the testing be used to corroborate present plans for treatment?

7. Designate who will perform psychological testing if not self:
Name: ____ Phone: ______________ Lic#: ____________

(Only independently licensed psychologists or LPA under delegation and supervision of psychologists are authorized to perform psychological testing.)

I hereby certify that I am the patient's therapist and the above statements are true and correct:

____
Name of Provider **Phone**

____
Address **City/State/Zip**

____
Signature of Provider **Date**

(FOR OFFICE USE ONLY)

This request for psychological testing has been:

☐ **APPROVED: Total Hours: _____________**

The tests approved above are the only tests which are being authorized. After the initial test results are evaluated, further testing may be indicated. If so, the provider should resubmit an update pre-certification form with a copy of previous test results attached.

☐ **NOT CERTIFIED**

The Medical Director reviews all requests, which are questioned by the Reviewer and must concur prior to denial.

____
Medical Director Signature **Date**