**Psychological Testing Prior Authorization Request**

Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance: CHIP STAR STAR Kids

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Member Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. Nature of personality

structure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

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

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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:

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Name of Provider Phone

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Address City/State/Zip

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Provider Signature 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 updated 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.

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Medical Director Signature Date