

SUBMIT TO  
**Utilization Management Department**  
Phone: 1.800.224.1991 Fax: 1.877.725.7751



## OUTPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

### MEMBER INFORMATION

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Member ID # \_\_\_\_\_  
SSN # \_\_\_\_\_  
Health Plan \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name \_\_\_\_\_  
Group Name \_\_\_\_\_  
Provider Tax ID# \_\_\_\_\_ NPI/# \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Referral Source \_\_\_\_\_

### PROVISIONAL DSM-IV 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"/> Other _____ |
| <input type="checkbox"/> Depression                        | <input type="checkbox"/> Poor academic performance       | _____                                |
| <input type="checkbox"/> Withdrawn/poor social interaction | <input type="checkbox"/> Behavior problems at home       | _____                                |
| <input type="checkbox"/> Mood instability                  | <input type="checkbox"/> Behavior problems at school     |                                      |
| <input type="checkbox"/> Psychosis/Hallucinations          | <input type="checkbox"/> Inattention                     |                                      |
| <input type="checkbox"/> Bizarre Behavior                  | <input type="checkbox"/> Hyperactivity                   |                                      |
| <input type="checkbox"/> Unprovoked agitation/aggression   | <input type="checkbox"/> Eating disorder symptoms: _____ |                                      |

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 in the past?

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

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

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

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

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

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

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

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

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

**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.).

**STANDARD REVIEW:**

Standard 14-day time frame will be applied.

**EXPEDITED REVIEW:** By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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