

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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Current Psychiatric Medication list with dosages and effect:

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