

SUBMIT TO
Utilization Management Department
 1100 Circle 75 Parkway, Suite 1100
 Atlanta, GA 30339
 Phone: 1.877.725.7748 FAX: 1.844.733.8482



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?

- Anxiety
- Depression
- Withdrawn/poor social interaction
- Mood instability
- Psychosis/Hallucinations
- Bizarre Behavior
- Unprovoked agitation/aggression
- Self-injurious Behavior
- Poor academic performance
- Behavior problems at home
- Behavior problems at school
- Inattention
- Hyperactivity
- Other _____
- 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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