SUBMIT TO
Utilization Management Department
PHONE: 1.888.282.7767 FAX 1.866.694.3649

nh healthy families™

PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM

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

Please indicate which level of care the member is currently engaged: _____ Inpatient _____ Outpatient

PATIENT INFORMATION

Name _____

Date of Birth _____

Member ID # _____

SS# _____

Health Plan Name _____

Referral Source _____

PROVIDER INFORMATION

Provider/Agency Group Name _____

Professional Credentials _____

Provider Tax ID# _____

Provider NPI/Sub Provider # _____

Address _____

Phone _____ Fax _____

CURRENT ICD 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☐ Withdrawn/poor social interaction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
☐ Eating disorder symptoms: _____
☐ Poor academic performance
☐ Behavior problems at home
☐ Behavior problems at school
☐ Inattention
☐ Hyperactivity
☐ Other _____

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?

MEMBER 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

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (i.e., teacher feedback, results of school standardized testing)?

_____

_____

_____

Date of Diagnostic Interview: _____

Has the patient had a Psychiatric Evaluation? ☐ Yes ☐ No If yes, date? _____

Basic Focus and Results _____

_____

CURRENT PSYCHOTROPIC MEDICATIONS

Prescriber: ☐ Psychiatrist ☐ General Practitioner ☐ Other

MEDICATION	DATE STARTED	COMPLIANT? (Y/N)

REQUEST FOR AUTHORIZATION

Please check only one code:

Psych Testing
- ☐ 96101
- ☐ 96102
- ☐ 96103

Aphasia Assessment
- ☐ 96105

Developmental Testing
- ☐ 96110 ☐ 96111 ☐ 96125

NeuroPsychTesting
- ☐ 96116
- ☐ 96118
- ☐ 96119
- ☐ 96120

Please list the tests planned to answer the clinical questions

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Number of units requested to complete tests _____

Provider Name _____ Provider Signature _____ Date _____

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