



# Request For Psychological Testing Preauthorization

Section 3.14

The testing provider must complete Section XI, *Requested Testing*. Either the provider making the referral or the testing provider may complete other sections of the form. Please provide all requested information, subject to applicable law. In most cases, an initial assessment by a behavioral health care provider must be administered before psychological testing will be authorized. **Authorization for psychological testing will not be considered until all sections of this form are completed. To avoid potential issues with reimbursement, psychological testing should not to be initiated until an authorization has been received.**

Please send the completed form to: Magellan Health Services at the address or fax number located on authorization correspondence received for this member, or obtain the proper address/fax number by calling the phone number on the member's benefit card.

**Please Print Clearly**

### I Personal Information

Patient's Name:	DOB:	Today's Date:
Insurance Plan:	Patient's ID or Policy Number:	Policy Holder Name and ID (if different from Patient):

### II Person or Agency Making Initial Request for Testing

<input type="checkbox"/> Psychologist: <input type="checkbox"/> Psychiatrist: <input type="checkbox"/> Psychotherapist:	<input type="checkbox"/> Court: <input type="checkbox"/> Parent: <input type="checkbox"/> Teacher:	<input type="checkbox"/> School Stagg (specify): <input type="checkbox"/> PCP/Medical Specialist (specify): <input type="checkbox"/> Other (specify):
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### III Testing Provider Information

Name/Degree:	Telephone:	Fax:
Address:	Email:	
Name of Agency/Organization:		

### IV Current or Provisional DSM-IV Diagnosis

	Code	Description
Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V: (current):		

### V What is the clinical question that needs to be answered by this testing? (Attach additional sheets if needed)


### VI Why can't this question be answered by a diagnosis interview of psychological/psychiatric records, or second opinion? (Attach additional sheets if needed)


**VII What are the current symptoms and/or functional impairments related to testing question?** (Attach additional sheets if needed)

**VIII How would the results of testing affect the treatment plan? (please be specific)** (Attach additional sheets if needed)

**IX Medical/Psychological Evaluation and Treatment: Residential Information**

1. Has patient had a diagnostic interview (90801)  No  Yes, Date:

2. Has patient had an evaluation by a psychiatrist?  No  Yes, Date:

3. Has patient had previous psychological testing?  No  Yes, Date: Focus:

4. If current request is ADHD related, indicate latest results of Conners' or similar ADHD ratings scales:

Positive  Inconclusive  Negative  N/A  (not ADHD related or no previous administration of ADHD rating scales)

5. Current Psychotropic Medications:  None  Unknown  Yes (include dose and date began):

**X Current Substance Use?**

Has member abused any substance in last 30 days?  No  Yes, elaborate:

**XI Required Testing:**

Total Number of Hours Requested:

Is testing primarily neuropsychological?  Yes  No

Names and Type(s) of Tests:	Time Requested (Include administration, scoring, interpretation and Reporting)	CPT Code per testing *

**\*If test is being administered by a Technician, please complete the Attestation form on page 3.**

**To Be Completed by Magellan Clinical Reviewer**

Authorized?  Yes  No

List all CPT codes and hours (if relevant):

Provider Number:

Explain your decision:

*If approved and provider needs ad hoc, send in ad hoc completed form.  
An authorization can be issued only after ad hoc is approved.*

Certification Number:

Clinical Reviewer Name/Degree:

Signature: \_\_\_\_\_

Date:



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### XII. Technician Attestation

If Technician CPT codes (96102 or 96119) are requested the following attestation must be completed by the supervising psychologist

I attest to the following:

1. The services billed under the technician CPT code(s) will be delivered by an individual who has the appropriate training and experience to administer these tests;
2. The services will be delivered under my direct personal supervision;
3. The services will be provided in the office/facility where I render psychological services;
4. My employment and supervision of the technician complies with all applicable state laws and regulations including those governing psychologists;
5. I am responsible for the quality and accuracy of the services provided by the technician; and
6. I am responsible for the analysis and interpretation of the test results and final report.

\_\_\_\_\_  
Signature of supervising psychologist:

Date: