



Request For Psychological Testing Preauthorization

The testing provider must complete Section IX, *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 is not to be initiated until an authorization has been received.** Please send the completed form to: Magellan Health Services, *Address or Fax of relevant Care Management Center*.

Please Print Clearly

I. Today's Date:	Insurance Plan:	
Member Name:	DOB:	Subscriber ID (If different from Member):
Member Unique ID or Policy #:		

II. Person or Agency Making Request For Testing:

- | | | |
|--|----------------------------------|--|
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Court | <input type="checkbox"/> School Staff (Specify): _____ |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Parent | <input type="checkbox"/> PCP/Medical Specialist: _____ |
| <input type="checkbox"/> Psychotherapist | <input type="checkbox"/> Teacher | <input type="checkbox"/> Other: _____ |

III. Testing Provider Information:

Name/Degree: _____ Telephone #: _____
 Address: _____ Fax #: _____ E-mail: _____

IV. Current or Provisional DSM-IV Diagnosis:

Code	Description
1. _____	_____
2. _____	_____
3. _____	_____

Relevant Axis III Conditions: _____

(For the following questions, attach additional sheet if needed.)

Va. What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records, or second opinion? _____

Vb. What are the current symptoms related to this question? _____

VI. How would the results of testing affect the treatment plan? _____



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VII. Medical/Psychological Evaluation and Treatment:

	Yes	No	
1. Has client had a diagnostic interview (90801)? Psychiatrist Evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of interview: _____ If yes, date of interview: _____
2. Previous Psychological Testing? Date? _____ Basic Focus _____	<input type="checkbox"/>	<input type="checkbox"/>	If ADHD related, indicate results of Conners' or similar ADHD ratings scales: _____ <input type="checkbox"/> Positive <input type="checkbox"/> Inconclusive <input type="checkbox"/> Negative <input type="checkbox"/> N/A
3. Current Psychotropic Medications Prescribed: <input type="checkbox"/> None <input type="checkbox"/> Unknown	Dose: _____	Began: _____	Medications: _____

VIII. Current Substance Use:

Is member actively abusing any substance? Yes No If yes, elaborate: _____

IX. Requested Testing:

Number of hours requested (total): _____ Is testing primarily neuropsychological? Yes No

Names and Type(s) of Tests:

Time Requested (include administration, scoring, interpretation and reporting) :

Psychologist- (P), Technician- (T)* or Computer- (C) Administered?

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

Completed by Magellan Clinical Reviewer *(this section may be deleted if not used)*

Authorized? Yes No List all CPT codes and hours (if relevant): _____: _____

Provider #: _____

Explain your decision in Comments section below.

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

Name/degree: _____ _____
Clinical Reviewer Date

Comments: _____

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X. 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