SUBMIT TO
Utilization Management Department
PHONE 1.855.766.1456 (HMO) 1.866.330.9368 (HMO SNP)
FAX 1.877.725.7751

allwell. FROM pa health & wellness

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 # _____

Referal 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- ☐ Withdrawn/poor social interaction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
- ☐ Eating disorder symptoms: _____
- ☐ 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?

HISTORY

Does the patient have any significant medical illnesses, history of developmental problems, head injuries, or seizures now or in the past?

☐ Yes ☐ No ☐ Uncertain 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.

_____
Clinician Signature Date

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

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