Prior Authorization Request
HP Enterprise Services - Nevada Medicaid and Nevada Check Up

Psychological Testing

Fax this request to: (866) 480-9903 Questions? Call: (800) 525-2395

DATE OF REQUEST: ____ / ____ / _____

RECIPIENT INFORMATION		
Recipient Name (Last, First, MI):		
Recipient ID:		DOB:
Address:		Phone:
City:	State:	Zip Code:
Responsible Party Name:		
Address:		Phone:
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION	
Referring Provider Name:	NPI:
Phone:	Fax:

PSYCHOLOGIST INFORMATION	
Psychologist Name:	NPI:
Phone:	Fax:

CLINICAL INFORMATION	
Date of Initial Clinical Interview:	Date of Testing:
Requested Testing *(enter the number of units for each code requested)*: ____96101 ____96102 ____96103	
Has previous testing been performed? ☐ No ☐ Yes: If yes, date: ____/____/_____	
Is this request for Healthy Kids (EPSDT) services? ☐ No ☐ Yes	
Current symptoms and relevant history:	
Referral Question *(specific reason for referral)*:	

Requested Tests	**Requested Tests *(Continued)***
1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Requesting Provider Signature:	**Date:**

HP ENTERPRISE SERVICES USE ONLY		
Codes and Units Approved:		
Approved From:	Approved Through:	
Codes and Units Denied:		
Denied From:	Denied Through:	
Reviewer Signature:		Date:

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