OUTPATIENT PSYCHOLOGICAL TESTING REQUEST

Referring Provider Name: (Primary BH Provider)	**Phone:**

REQUESTED PROVIDER INFORMATION

Requested Provider Name:	**Specialty** ☐ MD ☐ DO ☐ PhD/PsyD ☐ LCSW ☐ CSAC ☐ LMHC/LMFT ☐ APRN/NP
If affiliated with a Clinic/Facility, Please Indicate Facility Name:	Office Contact Person:
Phone:	**Fax:**

MEMBER INFORMATION

Member Name:	**Member ID:**	**DOB:**

REASON FOR REQUEST

A. TYPE OF TESTING REQUESTED (please select): ☐ Psychological ☐ Neuropsychological

(**NOTE**: Must provide documentation of acute brain insult or other Neuropsychological conditions & Psych test history to support Neuropsychological testing)

B. Please provide supporting history & reason for testing: ______________________________

C. Please indicate goal for testing: ______________________________

D. How will testing benefit the patient & provider: ______________________________

E. TESTS - Please list the recommended tests for this patient: ______________________________

Requested # of contact hours for testing: ________ Requested # of Visits: ________ Begin: ________ End: ________

Who will administer the tests (notate name/title): ______________________________

Notes/Comments:
(If Applicable)

Provider Signature: **Date:** ________

FOR ALOHACARE USE ONLY: PROGRAM: ☐ QU ☐ ACA ☐ ACAP AUTHORIZATION #: ________

Fiscal Yr. Benefit Count: ______________________________

Auth Svc: ______________________________

Approve Date: ________________ Denied Date: ________________

Denial Reason: ________________ Init/Date: ________________

ALOHACARE
1357 Kapiolani Blvd, Suite 1250, Honolulu, HI 96814
Phone: 973-2475 (Oahu) or 1-888-875-4979 (NI)
Fax: 973-6324 (Oahu) or 1-888-293-4580 (NI)

AC/BHPSYCHTEST
REV 8-2001/12-2005/9-2009
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