AmeriHealth
DISTRICT OF COLUMBIA

SUBMIT TO:
AmeriHealth D.C. Utilization Management
FAX: 855-410-6638
For assistance please call 800-408-7510.

PSYCHOLOGICAL/NEURO-PSYCHOLOGICAL TESTING REQUEST

Please print clearly – incomplete or illegible forms will delay processing.

Member Information

Patient Name: _____
Health Plan: _____
DOB: _____
SS#: _____
Patient ID#: _____
Referral Source: _____

Provider Information

(Please indicate by checking below, whether requested services should be authorized to the provider or agency.)

☐ Provider
☐ Group/ Agency Name: _____

Professional Credential: ☐ MD ☐ PhD ☐ Other: _____

Physical Address: _____

PHONE: _____ FAX: _____

Medicaid/TPI/NPI#: _____ Tax ID#: _____

Referral Reason/Question:

Testing will not be authorized under any of the following conditions:

1. Testing is primarily for educational or vocational purposes.
2. Testing is primarily for legal purposes.
3. The tests requested are experimental or have no documented validity.
4. The time requested to administer the testing exceeds established time parameters.
5. Testing is routine for entrance into a treatment program.

Is this testing required for educational purposes, behavioral health purposes, or both?

Explain

State how the anticipated results of the testing will effect the patient's treatment plan:

DSM IV Axis

AXIS I	R/O	R/O
AXIS II		
AXIS III		
AXIS IV		
AXIS V	CURRENT	PAST YEAR

Danger to Self or Others? ☐ Yes ☐ No
If Yes, please explain:

MSE Within Normal Limits? ☐ Yes ☐ No
If No, please explain:

List Current Medications:

Name/Strength	Directions

What are the Current Symptoms Prompting the Request for Testing?

☐ Anxiety
☐ Depression
☐ Inattention
☐ Confusion
☐ Hypoactivity
☐ Hyperactivity
☐ Psychosis/Hallucinations
☐ Bizarre Behavior
☐ Unprovoked Agitation/Aggression
☐ Self-Injurious Behavior
☐ Eating Disorder Symptoms
☐ Withdraw/Poor Social Interaction
☐ Mood Instability
☐ Changes in memory capacity
☐ Changes in cognitive capacity
☐ Behavior Problems affecting life functions (e.g., school, home)
☐ Poor Academic Performance
☐ Other, List _____

Comment/Explain:

Was a Behavioral Health Evaluation completed (e.g., 90801)?

☐ Yes ☐ No Date: _____

Results:

_____

_____

_____

Was Previous Psychological or Neuropsychological Testing Conducted?

☐ Yes ☐ No Date: _____

Basic Focus and Results: _____

_____

_____

_____

HISTORY

When was the patient's last physical examination?

If ADHD is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available:

☐ Positive ☐ Negative ☐ Inconclusive ☐ Not Applicable

Comment/Explain:

Start Date MM/DD/YY	Stop Date MM/DD/YY	CPT code	Modifier(s)	Units Requested

Please list the tests planned to answer the clinical questions:

Test	Reason for Use	Educational Yes/No	Number of Units Requested for Test	Number of Units Approved for Test

Indicate the total number of units (hours) requested: _____

Provider Signature: _____

Date: _____