Request for psychological testing

Please submit your request **prior** to providing services, otherwise payment may be denied. **Fax to:** Delaware Physicians Care Behavioral Health Services at **1-866-543-2384** or **Call**: **1-866-543-2383**

Date of Request: _____

Patient Name: _____ Date of Birth: _____

Member ID#: _____

Person/Agency Requesting the Psychological Testing:

☐ Psychologist ☐ Court ☐ School

☐ Psychiatrist ☐ Parent ☐ PCP/Medical Specialist

☐ Psychotherapist ☐ Teacher ☐ Other: _____

Clinician to Complete Testing:

Name/Degree: _____

Telephone: _____ Fax: _____

Patient Information:

Please attach a copy of the most recent psychiatric/psychological diagnostic assessment (90801) report.

1. What are the specific questions to be answered by the psychological testing?

_____

_____

_____

Patient Name: _____ DOB: _____

2. What information is the psychological testing expected to provide that cannot be determined through other means, such as a comprehensive clinical assessment, a review of pertinent records, a medication review, use of observational rating scales, or second opinions?

   _____

   _____

   _____

3. How will the results of the testing be used to guide treatment decisions?

   _____

   _____

   _____

4. Total number of hours requested: _____

5. Please check appropriate CPT code:

Psych testing: ____ 96101 Neuropsych testing: _____96118 _____96119 _____96120

Complete names and types of tests:

Time requested for administration, scoring, interpretation and report preparation of each test: