Magellan Complete Care
PO Box 524083
Miami, FL 33152

Magellan COMPLETE CARE

The testing provider must complete Section IX, Requested *Testing.* Either the provider making the referral or the testing provider may complete other sections of the form. Please provide all the requested information, subject to applicable law. In most cases, an initial assessment by a behavioral health care provider must be administered before psychological testing will be authorized. **Authorization for psychological testing will not be considered until all sections of this form are completed. To avoid potential issues with reimbursement, psychological testing is not to be initiated until an authorization has been received.**

Please send the completed form to: Magellan Complete Care 888-656-4894 (FAX)
For Prior Authorization questions, call Customer Services at (800) 327-8613

Today's Date: _____

I. Enrollee Name: _____ Member #: _____ DOB: _____

II. Requesting Provider:

☐ Psychologist ☐ Court ☐ School Staff (Specify): _____
☐ Psychiatrist ☐ Parent ☐ PCP/ Medical Specialist: _____
☐ Psychotherapist ☐ Teacher ☐ Other: _____

III. Testing Provider Information:

Name: _____Phone#: _____

Degree: _____Fax #: _____

Address: _____

E-mail: _____

IV. Current or Provisional DSM-IV Diagnosis:

	Code	**Description**
1.	_____	_____
2.	_____	_____
3.	_____	_____

Relevant Axis III Conditions: _____

Approval by AHCA BH 5/23/2013 to 8/31/2015

Va. What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records, or second opinion? _____
_____
_____
_____
_____

Vb. What are the current symptoms related to this question? _____
_____
_____
_____

VI. How would the results of testing affect the treatment plan? _____
_____
_____
_____
_____

VII. Medical/Psychological Evaluation and Treatment:

	Yes	No	
1. Has client had a diagnostic interview (90801)? Psychiatrist Evaluation?	☐ ☐	☐ ☐	If yes, date of interview: _____ If yes, date of interview: _____
2. Previous Psychological Testing? Date? _____ Basic Focus _____	☐	☐	If ADHD related, indicate results of Conners' or similar ADHD ratings cales: _____ Positive ☐Inconclusive ☐Negative ☐N/A
3. Current Psychotropic Medications Prescribed: ☐None ☐ Unknown	Dose:	Began:	Medications:

VIII. Current Substance Use:
Is enrollee actively abusing any substance? ☐ Yes ☐ No If yes, elaborate: _____
_____

IX. Requested Testing:
Number of hours requested (total): _____ Is testing primarily neuropsychological? ☐ Yes ☐ No

Names and Type(s) of Tests:	**Time Requested** (include administration, scoring, interpretation and reporting):	**Psychologist- (P), Technician- (T)* or Computer- (C) Administered?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Testing start date: _____ Anticipated completion date: _____

***If test is being administered by a Technician, please complete the Attestation**

Completed by Magellan Clinical Reviewer *(this section may be deleted if not used)*

Authorized? ☐ Yes ☐ No List all CPT codes and hours (if relevant): _____:_____

Provider #: _____

Explain your decision in Comments section below.

If approved and provider needs ad hoc, send in ad hoc completed form. Certification # : _____

An authorization can be issued only after ad hoc is approved.

Name/degree _____ _____

Clinical Reviewer Date

Comments:

_____

_____

_____

X. Technician Attestation

If Technician CPT codes (961020 or 96119) are requested the following attestation must be completed by the supervising psychologist.

I attest the following:

1) The services billed under the technician CPT code(s) will be delivered by an individual who has the appropriate training and experience to administer these tests;
2) The services will be delivered under my direct personal supervision;

3) The services will be provided in the office/facility where I render psychological services;
4) My employment and supervision of the technician complies with all applicable laws and regulations including those governing psychologists;
5) I am responsible for the quality and accuracy of the services provided by the technician; and
6) I am responsible for the analysis and interpretation of the test results and final report.

_____ _____

Signature of supervising psychologist Date