

PRECERTIFICATION FOR PSYCHOLOGICAL TESTING

In order to be authorized, psychological testing must be needed to establish a differential diagnosis that is crucial to establishing or modifying a treatment plan. Before requesting authorization for neuropsychological testing you must complete a face-to-face evaluation of sufficient detail to answer the questions on the authorization form. Additionally, testing must not be available from any other source, and any previous psychological testing results are either unavailable or more than 18 months old. Testing requested primarily for legal, employment, vocational, or educational purposes is most often not a covered benefit.

Testing is encouraged only when clearly indicated and necessary for treatment. This report must be received and certified by MHNet prior to testing. If testing is deemed clinically urgent and completion must be immediate, the request can be made by calling MHNet at the Customer Service number on the patient's ID card and requesting to speak with one of our Case Managers. In the event a Case Manager is not available you may speak with one of our Outpatient clinical supervisors.

PATIENT NAME	D.O.B.	AGE	
INSURANCE PLAN	ID #		
INSURED'S NAM E	EM PLOYER GROUP	EM PLOYER GROUP	
Current Diagnoses under evaluation (DSM 5) Diagnoses	Current Acute Clinical Symptoms		
Patient referred to Requesting Psychologist b	y: (Name, Degree, Specialty, Phone)		
Name	Degree		
Phone	Specialty		

1. Clinical interview data: (psycho/social/behavioral history, mental status exam, medications, impairments in functioning, etc.):

2. Purpose of testing (include referral question, differential diagnostic issues to be addressed, how treatment plan will be affected by results of testing):

3. Have resources for psychological evaluation been explored through the patient's place of employment or school?

Explain YES NO

4. Which of the following diagnostic / assessment techniques have been completed?

- Diagnostic Interview
- **Clinical Review**
 - Brief Rating Scale (e.g., BDI)

- ____ Mental Status Exam
- Comprehensive Psycho-social-behavioral History
- _____ Behavioral Observation



5. a.	<u>Clinical Questions</u> Organic/Neuro to include: - Memory - Language - Attention - Executive Function		(s) Requested	<u>Hours</u>	
b.	Learning Disabilities (not usually a covered benefit)				
c.	Affective/Behavioral				
d.	Personality				
e.	Other (e.g., Evaluation for Medical Procedures (Gastric Bypass, Stimulator, Transplant)				
CPT Cod	e(s) requested:		Hours:		
			Total Time Requested:		
I hereby certify that I am the practitioner who will be performing the testing and the above statements are true and correct:					
Name of	Provider Pr	ovider TIN	Signature of Provider/Date		
Address		City	State	Zip Code	
Provider	Telephone Number	Prov	rider Fax Number		
Note: Incomplete forms may lead to delays in processing the request or lack of authorization.					
PLEASE FAX FORMS TO:					
MHNet Commercial and Medicare members: (724) 741-4556					
CovCares of Virginia (Medicaid): (800) 586-7015 HCUSA (Medicaid): (866) 341-1327		0-1012	CovCares of Kentucky (Medicaid): (844) 885-0699 CovCares of Michigan: (866) 603-5535		