Select Health of South Carolina | Healthy Connections

Neuropsychological Testing Request ☐
Psychological Testing Request ☐

Please check one of the above. When complete, please fax to 1.888.796.5521.
Please type or print clearly. Incomplete and illegible forms will delay processing.

1. Member Information

Member name _____ First Choice ID# _____ SSN _____ DOB _____

Member address _____ City, State Zip _____ Phone _____

Who referred member for treatment? ☐ Self/parent ☐ PCP ☐ School ☐ State agency _____ ☐ Other _____

2. Treating Provider Information

Name (include credentials) _____ NPI # _____ Phone _____

Address _____ City, State Zip _____ Fax _____

Group name/ID number _____ Contact name _____ Treating provider signature _____

3. Testing Requested: Neuropsychological: ____ 96118 ____ 96119 ____ 96120 Psychological: ____ 96101

4. Referral Reason and Functional Impairment _____

5. How will the anticipated results affect the member's treatment plan? _____

6. DSM-IV Multi-axial Diagnosis *Please complete all 5 axes*

Axis I	□□□.□□/□□□.□□
Axis II	□□□.□□/□□□.□□
Axis III	
Axis IV	☐ Mild ☐ Moderate ☐ Severe
Axis V: GAF	Current: Past year:

7. Check Current Symptom(s) Prompting Request for Testing:

☐ Anxiety ☐ Inattention ☐ Withdrawal/poor social interaction
☐ Psychosis/hallucinations ☐ Hyperactivity ☐ Unprovoked agitation/aggression
☐ Mood instability ☐ Depression ☐ Poor academic performance
☐ Bizarre behavior ☐ Self-injurous behavior ☐ Eating disorder symptoms
☐ Behavior problems affecting life functions (e.g. school, home)
☐ Other, please list _____

8. Current Medications *list with dosages or attach sheet* _____

9. Check All Assessments to Date

☐ No assessment procedures performed to date ☐ Structured interview ☐ Clinical interview with patient
☐ Direct observation of parent/child interaction ☐ Interview with family ☐ Brief inventories or rating scales
☐ Assessment by mental health professional(s) ☐ Medical evaluation ☐ Consultation with patient's physician
☐ Consultation with school personnel or others ☐ Review of records of previous treatment ☐ Other, please list _____

10. Please answer the following. *Attach additional pages/records if necessary.*

Patient medical and psychiatric history _____

Family medical and psychiatric history _____

Describe any neurological incidents or events and/or neuro-developmental concerns _____

History of psychological testing and results/findings _____

11. Description of Testing Request

Test to be administered	Time required *(administration of test, scoring, interpretation and report preparation)*	Comments

12. Authorization Request

Service code _____ Hours _____ Request start date _____ | Service code _____ Hours _____ Request start date _____

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For Select Health use only

Auth # _____ Date communicated to provider _____ Staff initials/name _____

Auth code _____ Units _____ Start date _____ End date _____

Auth code _____ Units _____ Start date _____ End date _____

Auth code _____ Units _____ Start date _____ End date _____

Auth code _____ Units _____ Start date _____ End date _____