Request for Authorization: Psychological Testing

Please submit this form using our preferred method at **https://www.availity.com**.* You may also submit this form via fax to **1-844-442-8014**.

General information

Member name:			
Member date of birth:		**Member ID:**	
Provider completing testing:			
Provider phone:		**Provider fax:**	
Provider ID or tax ID:		**Provider NPI:**	
Provider address:			
Provider email:			

Formal psychological testing is neither clinically indicated for routine screening or assessment of behavioral health disorders nor indicated for the administration of brief behavior rating scales and inventories. Such scales and inventories are an expected part of a routine and complete diagnostic process. Other than in exceptional cases, a diagnostic interview and relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization.

Requests for placement purposes and forensic purposes are not covered benefits. Requests for educational testing or learning disabilities assessment for educational purposes should be referred to the public school system.

Clinical assessment: Indicate which of the following assessments have been completed.

☐ Brief inventories and/or rating scales	☐ Structured developmental and social history	☐ Psychiatric and medical history	☐ Review of academic records/Individualized Education Program
☐ Clinical interview with patient	☐ Review of medical records	☐ Medical evaluation	☐ Consultation with school/other important persons
☐ Consultation with patient's physician	☐ Family history pertinent to testing request	☐ Interview with family members	☐ Direct observations of patient-child interactions

* Availity, LLC is an independent company providing administrative support services on behalf of Summit Community Care.

Clinical information: Indicate which of the following problems and symptoms presented a need for testing.

☐ Acting out behavior	☐ Depression	☐ Impulsivity	☐ Lethargy	☐ Other developmental delays
☐ Anxiety	☐ Disorganization	☐ Inattention	☐ Low frustration tolerance	☐ Speech and language delays
☐ Attention seeking	☐ Distractibility	☐ Irritability	☐ Low motivation	☐ Suicidal or homicidal ideation
☐ Delusions	☐ Hallucinations	☐ Labile mood	☐ Poor attention span	☐ Violence or physical aggression
☐ Other:				
Duration of symptoms: ☐ 0 to 3 months ☐ 3 to 6 months ☐ 6 to 9 months ☐ 9 to 12 months ☐ > 12 months				

Treatment history: Please provide information regarding treatment history.

	Frequency	How long has member been in treatment?	Is member still in treatment?	Have symptoms improved?
Individual therapy:				
Medication Management:				
School- or home-based:				
Other services:				

Date of diagnostic interview:	

Rating scales: Please indicate which rating scales have been administered as part of your clinical assessment.

☐ Achenbach	☐ ADHD rating	☐ BAI	☐ BASC	☐ BDI
☐ Brief	☐ CBCL	☐ CDI	☐ Conner's	☐ MASC
☐ MDQ	☐ PCL-5	☐ RAD	☐ STAI	☐ TSCC
☐ Other:				
Please include any pertinent results of rating scales.				

Other pertinent information

Please include any other information that supports the request for psychological testing.

Previous psychological testing

Please include any information regarding previous psychological testing (such as dates of testing or results) and why retesting is requested.

DSM-5/ICD-10 diagnoses

Rationale for testing

Please describe the rationale for testing. What are the current questions to be answered that cannot be addressed by the clinical interview, review of records and rating scales that you have already administered? How will the results of testing impact the course of treatment?
Is this a request for a trauma assessment? ☐ Yes ☐ No

Psychological tests and services being requested

CPT® code(s)	Units requested	Test names/service description

Total units requested:		**Total time requested:**	

Provider signature:		**Date:**	