ambetter. FROM peach state health plan

SUBMIT TO:
Utilization Management Department
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
PHONE 1.877.687.1180
Inpatient Fax 844.561.7857
Outpatient Fax 844.256.1291

PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM

***All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.**

Please indicate which level of care the member is currently engaged: ☐ INPATIENT ☐ OUTPATIENT

IDENTIFYING INFORMATION

Member Name _____ DOB _____ SSN _____

Member ID # _____ Health Plan Name _____

Provider Name _____ OR Agency/Group Name _____

Professional Credentials _____

Provider Phone # _____ Fax # _____

Address (street/city/state) _____

NPI # _____ Tax ID # _____

Referral Source _____

DIAGNOSIS (PLEASE REPORT ALL DIAGNOSES BEING CONSIDERED FOR THIS MEMBER)

Primary (Required) _____ R/O _____ R/O _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Danger to Self or Others (If yes, please explain)? ☐ Yes ☐ No _____

_____

MSE Within Normal Limits (If no, please explain)? ☐ Yes ☐ No _____

_____

WHAT ARE THE CURRENT SYMPTOMS PROMPTING THE REQUEST FOR TESTING?

☐ Anxiety	☐ Psychosis/Hallucinations	☐ Eating disorder symptoms	☐ Inattention
☐ Depression	☐ Inexplicable Behavior	☐ Poor academic performance	☐ Hyperactivity
☐ Withdrawn/poor social interaction	☐ Unprovoked agitation/agression	☐ Behavior problems at home	☐ Other
☐ Mood instability	☐ Self-injurious Behavior	☐ Behavior problems at school	_____

What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing affect the care and treatment in a meaningful way?

_____

_____

_____

_____

_____

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MEMBER HISTORY

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past? ☐ Yes ☐ No

Comments _____

Does the patient have a family history of psychiatric disorders, behavior problems or substance use? ☐ Yes ☐ No ☐ Uncertain

Comments _____

Is there any known or suspected history of physical or sexual abuse or neglect? ☐ Yes ☐ No ☐ Uncertain

Comments _____

If ADHD is a diagnostic rule out, please complete the following: Is the patient's presentation on intake consistent with ADHD? ☐ Yes ☐ No

Indicate the results of Conner's or similar ADHS rating scales, if given: ☐ Positive ☐ Negative ☐ Inconclusive ☐ N/A

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (i.e., teacher feedback, results of school standardized testing) _____

_____

Date of Diagnostic Interview _____

Has the patient had a Psychiatric Evaluation? ☐ Yes ☐ No If yes, date of the interview _____

Previous Psychological Testing? ☐ Yes ☐ No If yes, date? _____

Basic Focus and Results _____

CURRENT PSYCHOTROPIC MEDICATIONS

Prescriber: ☐ Psychiatrist ☐ General Practitioner ☐ Other

Medication Name	Date Started	Compliant? (Y/N)

REQUEST FOR AUTHORIZATION

Please check only one code:

Psych Testing:
☐ 96101 ☐ 96102 ☐ 96103

NeuroPsych Testing:
☐ 96116 ☐ 96118 ☐ 96119 ☐ 96120

Aphasia Assessment: ☐ 96105

Developmental Testing:
☐ 96110 ☐ 96111 ☐ 96125

Please list the tests planned to answer the clinical questions.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Number of units requested to complete tests: _____

Provider Name _____

Provider Signature _____ Date _____

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).