AmeriHealth Caritas
District of Columbia

Psychological and Neuropsychological Testing Request

Please print clearly — incomplete or illegible forms will delay processing.

Member information

Patient name: _____

Health plan: _____

Date of birth: _____

Social Security number: _____

Patient ID number: _____

Referral source: _____

Provider information

(Please indicate by checking below whether requested services should be authorized to the provider or agency.)

☐ Provider

☐ Group or agency | Name: _____

Professional credential: ☐ M.D. ☐ Ph.D. ☐ Other: _____

Physical address:

Phone: | Fax:

Medicaid/TPI/NPI number: | Tax ID number:

Referral reason or question:

Testing will not be authorized under any of the following conditions:

1. Testing is primarily for educational or vocational purposes
2. Testing is primarily for legal purposes
3. The tests requested are experimental or have no documented validity
4. The time requested to administer the testing exceeds established time parameters
5. Testing is routine for entrance into a treatment program

Is this testing required for educational purposes, behavioral health purposes, or both? Explain:

State how the anticipated results of the testing will affect the patient's treatment plan:

DSM IV axis

AXIS I	R/O	R/O
AXIS II		
AXIS III		
AXIS IV		
AXIS V	CURRENT	PAST YEAR

Danger to self or others? ☐ Yes ☐ No

If yes, please explain:

Mental status exam (MSE) within normal limits? ☐ Yes ☐ No

If no, please explain:

List current medications:

Name and strength	Directions

What are the current symptoms prompting the request for testing?

- ☐ Anxiety
- ☐ Depression
- ☐ Inattention
- ☐ Confusion
- ☐ Hypoactivity
- ☐ Hyperactivity
- ☐ Psychosis/hallucinations
- ☐ Bizarre behavior
- ☐ Unprovoked agitation or aggression
- ☐ Self-injurious behavior
- ☐ Eating disorder symptoms
- ☐ Withdrawing or poor social interaction
- ☐ Mood instability
- ☐ Changes in memory capacity
- ☐ Changes in cognitive capacity
- ☐ Behavior problems affecting life functions (e.g., school, home)
- ☐ Poor academic performance
- ☐ Other, list: _____

Comments:

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Was a behavioral health evaluation completed (e.g., 90801)?	History
☐ Yes ☐ No Date: _____ Results: _____ _____ Was previous psychological or neuropsychological testing conducted? ☐ Yes ☐ No Date: _____ Basic focus and results: _____ _____	When was the patient's last physical examination? If attention-deficit/hyperactivity disorder (ADHD) is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available: ☐ Positive ☐ Negative ☐ Inconclusive ☐ Not applicable Comments:

Start date MM/DD/YY	Stop date MM/DD/YY	CPT code	Modifiers	Units requested

Please list the tests planned to answer the clinical questions.

Test	Reason for use	Educational (yes or no)	Number of units requested for test	Number of units approved for test

Indicate the total number of units (hours) requested:

Provider signature:

Date:

Submit to:
AmeriHealth Caritas DC Utilization Management
Fax: **1-855-410-6638**
For assistance, please call **1-800-408-7510**.

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GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

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