

**In-network provider:** Instead of completing this form, sign in to [www.MagellanProvider.com](http://www.MagellanProvider.com) and complete the request securely online (select *Request Member Care* from the left menu), or complete this form and upload it directly.

The testing provider must complete Section XI, *Requested Testing* and, if applicable, Section XIII, *Technician Attestation*. Either the referring provider or the testing provider may complete other sections of the form. Please provide all requested information, subject to applicable law. In most cases, an initial assessment by a behavioral healthcare provider must be administered before psychological testing will be authorized.

**Authorization for psychological testing will not be considered until all sections of this form are completed. To avoid potential issues with reimbursement, psychological testing should not be initiated until an authorization has been received.**

**Out-of-network provider:** Send this completed form to **Magellan Healthcare** at the address or fax number located on authorization correspondence received for this member, or obtain the proper address/fax number by calling the phone number on the member's benefit card.

**Please print clearly – Complete all items – Incomplete forms cannot be processed**

**I.**

Today's Date: \_\_\_\_\_ Insurance Plan: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_ Policy Holder Name (if different from pt): \_\_\_\_\_  
 Patient's DOB: \_\_\_\_\_ Policy Holder ID (if different from pt): \_\_\_\_\_  
 Patient's Unique ID or Policy #: \_\_\_\_\_ Policy Holder Address: \_\_\_\_\_  
 Requested Start Date of Auth: \_\_\_\_\_

**II. Person or Agency Making the Initial Referral to the Testing Psychologist:**

Psychiatrist                       Other Psychologist                       School Staff (Specify): \_\_\_\_\_  
 Psychotherapist                   Parent     PCP/Medical Specialist: \_\_\_\_\_  
 Testing Psychologist               Court     Other: \_\_\_\_\_

**III. Testing Provider Information:**

Name: \_\_\_\_\_ Degree: \_\_\_\_\_  
 Name of Agency/Org: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Extension: \_\_\_\_\_  
 \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Service Address: \_\_\_\_\_ Email: \_\_\_\_\_  
 \_\_\_\_\_ NPI: \_\_\_\_\_ TaxID: \_\_\_\_\_  
 City, State: \_\_\_\_\_ ZIP: \_\_\_\_\_ TaxID Owner Name: \_\_\_\_\_

**IV. ICD-10 Diagnosis:**

Code	Current or Provisional Diagnosis	Description
_____	<input type="checkbox"/> Current <input type="checkbox"/> Provisional	_____
_____	<input type="checkbox"/> Current <input type="checkbox"/> Provisional	_____
_____	<input type="checkbox"/> Current <input type="checkbox"/> Provisional	_____

(For the following questions, attach additional sheet if needed.)

**V. What is the clinical question that needs to be answered by testing?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Request for Psychological Testing Preauthorization**

**VI. Why can't this question be answered by a diagnostic interview, a medical and/or neurological consult, review of psychological/psychiatric records, or second opinion?** \_\_\_\_\_

**VII. What are the current symptoms and/or functional impairments related to testing question?** \_\_\_\_\_

**VIII. How would the results of testing affect the treatment plan (be specific)?**  
(Item VIII is not applicable in New Jersey.) \_\_\_\_\_

**IX. Medical/Psychological Evaluation and Treatment:**

1. Has the testing psychologist or other behavioral health professional completed an initial diagnostic evaluation [90791 (no med svcs) or 90792 (w/med svcs)] OR initial office visit with E/M services (99203, 99204, 99205)?

- Yes If yes, date of evaluation: \_\_\_\_\_
- No

2. Has patient had an evaluation by a psychiatrist?  Yes If yes, date of evaluation: \_\_\_\_\_  
 No

3. Has patient had previous psychological testing?  Yes If yes, date: \_\_\_\_\_ Focus: \_\_\_\_\_  
 No

4. If the current testing request is ADHD-related, indicate latest results of Conners or similar ADHD rating scales:

- Testing is not ADHD-related
- Rating scales were positive
- Rating scales were inconclusive
- Rating scales were negative
- Rating scales were not administered

5. Current psychotropic medications (include *dose* and *date began*): \_\_\_\_\_

- None
- Unknown

**X. Current Substance Use:** Has member abused any substance in last 30 days?  Yes  No

If yes, elaborate: \_\_\_\_\_

**XI. Requested Testing:** (This section must be completed by the testing psychologist.)

**Names and Type(s) of Tests:**

(To avoid confusion or processing delays, please print clearly and **be precise** when listing test names/acronyms.)

**USE ONLY APPROVED CODES BELOW IN SECTION XII.**

## Request for Psychological Testing Preauthorization

### XII. Magellan CPT® Codes for Psychological and Neuropsychological Testing Services

CPT® Codes and Descriptions <sup>1</sup> <i>For services rendered on or after Jan. 1, 2019</i>	CPT Codes and Number of Requested Units
<b>96130</b> Psychological testing evaluation services by physician or other QHP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s) when performed, <b>first hour</b>	_____ <b>unit</b> <i>(Only <u>one</u> unit of one hour allowed)</i>
<b>+96131</b> Psychological testing evaluation services, by physician or other QHP, each additional hour	_____ <b># of additional hours</b>
<b>96132</b> Neuropsychological testing evaluation services by physician or other QHP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s) when performed, <b>first hour</b>	_____ <b>unit</b> <i>(Only <u>one</u> unit of one hour allowed)</i>
<b>+96133</b> Neuropsychological testing evaluation services by physician or other QHP, each additional hour	_____ <b># of additional hours</b>
<b>96136</b> Psychological or neuropsychological test admin and scoring by physician or other QHP, two or more tests, any method, first 30 minutes	_____ <b>unit</b> <i>(Only <u>one</u> unit of 30 minutes allowed)</i>
<b>+96137</b> Psychological or neuropsychological test admin and scoring by physician or other QHP, two or more tests, any method, each additional 30 minutes	_____ <b>unit(s)</b> <i>(# of additional units of 30 minutes each)</i>
<b>96138</b> Psychological or neuropsychological test admin and scoring by technician, two or more tests, any method, first 30 minutes	_____ <b>unit</b> <i>(Only <u>one</u> unit of 30 minutes allowed)</i>
<b>+96139</b> Psychological or neuropsychological test admin and scoring by technician, two or more tests, any method, each additional 30 minutes	_____ <b>unit(s)</b> <i>(# of additional units of 30 minutes each)</i>
<b>96146</b> Psychological or neuropsychological test admin, with single automated, standardized instrument via electronic platform, with automated result only	_____ <b>unit</b> <i>(Only <u>one</u> unit allowed)</i>
<b>Total number of hours requested (count automated test admin as one hour):</b>	_____ <b>total hours</b> <i>(may include .5 to represent half an hour e.g., 5.5)</i>

**Please note:** Codes on reimbursement schedules may vary by state or plan. Nothing in this document should be construed as altering your currently contracted services. There may be codes above for which you are not contracted. The presence of them here does not add them to your current contract.

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### XIII. Technician Attestation: If technician CPT codes (96138 or 96139) are requested, the supervising psychologist must complete the following attestation. **I attest to the following:**

1. The services billed under the technician CPT code(s) will be delivered by an individual who has the appropriate training and experience to administer these tests;
2. The services will be delivered under my direct personal supervision;
3. The services will be provided in the office/facility where I render psychological services;
4. My employment and supervision of the technician complies with all applicable state laws and regulations including those governing psychologists;
5. I am responsible for the quality and accuracy of the services provided by the technician; and
6. I am responsible for the analysis and interpretation of the test results and final report.

\_\_\_\_\_  
Signature of supervising psychologist

\_\_\_\_\_  
Date