MAGELLAN HEALTH SERVICES
Getting Better All the Time

Request For Psychological Testing Preauthorization

The testing provider must complete Section XI, *Requested Testing*. Either the provider making the referral 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 health care 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.**
Please send the completed form to: Magellan Health Services 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

I. Today's Date:	**Insurance Plan:**	
Patient's Name:	**Patient's DOB:**	**Policy Holder Name and ID (If different from Patient):**
Patient's Unique ID or Policy #:		

II. Person or Agency Making the *Initial* Request for Testing:

☐ Psychologist	☐ Court	☐ School Staff (Specify):
☐ Psychiatrist	☐ Parent	☐ PCP/Medical Specialist:
☐ Psychotherapist	☐ Teacher	☐ Other:

III. Testing Provider Information:

Name/Degree:	Telephone #:	
Address:	Fax #:	E-mail:
	Name of Agency/Org:	

IV. Current or Provisional DSM-IV Diagnosis:

Code	Description
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V (current):	

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

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 (please be specific)?

IX. Medical/Psychological Evaluation and Treatment:

1. Has patient had a diagnostic interview (90801)? Yes ☐ Date: No ☐

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2. Has patient had an evaluation by a psychiatrist? Yes ☐ Date: No ☐

3. Has patient had previous psychological testing? Yes ☐ Date: Focus: No ☐

4. If current request is ADHD related, indicate latest results of Conners' or similar ADHD ratings scales:
Positive ☐ Inconclusive ☐ Negative ☐ N/A ☐ (not ADHD related or no previous administration of ADHD rating scales)

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:

Number of hours requested (total): Is testing primarily neuropsychological? ☐ Yes ☐ No

Names and Type(s) of Tests:	**Time Requested** (include administration, scoring, interpretation and reporting) :	**CPT Code per test**

XII. Technician Attestation—If Technician CPT codes (96102 or 96119) are requested the following attestation must be signed and dated by the supervising psychologist.

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

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Completed by Magellan Clinical Reviewer ***(this section may be deleted by the CMC if not used)***

Authorized? ☐ Yes ☐ No List all CPT codes and hours (if relevant):______________

Provider #:____

Explain your decision in Comments section below.

If approved and provider needs ad hoc, send in ad hoc completed form. Certification #: ____________________________________

An authorization can be issued only after ad hoc is approved.

Name/degree:____ ________________________

Clinical Reviewer Date

Comments: ____

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