Magellan HEALTHCARE

Request For Psychological Testing Preauthorization

The testing provider must complete Section XI, *Requested Testing* and, if applicable, Section XII, *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 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:	**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 for Testing:

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

III. Testing Provider Information:

Name: _____ Degree: _____ Telephone #: _____ Extension: _____
Name of Agency/Org:_____ Fax #: _____ Email: _____
Address: _____ TaxID: _____ NPI: _____
City, State: _____ Zip: _____ TaxID Owner Name:_____

IV. DSM-5 Diagnosis:

Code	Current or Provisional Diagnosis		Description
_____	Current ☐	Provisional ☐	_____
_____	Current ☐	Provisional ☐	_____
_____	Current ☐	Provisional ☐	_____

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

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)?
(Item VIII is not applicable in New Jersey) _____

_____

_____

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IX. Medical/Psychological Evaluation and Treatment:

1. Has the testing psychologist or other behavioral health professional completed a psychiatric 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 ☐ 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: (Please print clearly and be precise when indicating the names or acronyms of the tests to avoid confusion)	**Time requested per test** (include administration, scoring, interpretation and reporting) :	Is testing primarily neuropsychological? ☐ Yes ☐ No **CPT Code per test**
Total number of hours requested:		**Please read instructions re: billing rules**

XII. Technician Attestation: If Technician CPT codes (96102 or 96119) are requested the following attestation must be completed 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