Magellan HEALTHCARE℠

REQUEST FOR PSYCHOLOGICAL TESTING PREAUTHORIZATION

Either the provider making the referral for psychological testing or the provider conducting the testing must complete this form; however, the completed form must be reviewed and approved by the testing provider. 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 is not to be initiated until an authorization has been received.**

Please fax the completed form to the respective care manager at 1-866-667-7744.

PLEASE TYPE OR PRINT CLEARLY

I. TODAY'S DATE:		**Insurance Plan:**	
Member Name:		**DOB:**	**Subscriber ID (If different from Member):**
MA ID #:			

II. PERSON OR AGENCY MAKING REQUEST FOR TESTING:

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

III. REFERRING PROVIDER INFORMATION:

Name/Degree: _____
Address: _____
_____
Telephone #: _____
Fax #: _____

TESTING PROVIDER INFORMATION:

Name/Degree: _____
Address: _____
_____
Telephone #: _____
Fax #: _____ E-mail: _____

IV. CURRENT OR PROVISIONAL DSM-5 DIAGNOSIS and ICD 10 Code:

_____
_____
_____
_____

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

V. What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records, or second opinion?

_____
_____
_____
_____
_____

VI. What are the current symptoms related to this question?

_____
_____
_____
_____
_____

VII. How would the results of testing affect the treatment plan?

_____
_____
_____
_____
_____
_____
_____

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VIII. MEDICAL/PSYCHOLOGICAL EVALUATION AND TREATMENT:

	Yes	No	
1. Has client had a diagnostic interview (90791 or 90792)? Psychiatrist Evaluation?	☐ ☐	☐ ☐	If yes, date of interview: _____ If yes, date of interview: _____
2. Previous Psychological Testing? Date? _____ Basic Focus: _____	☐	☐	If ADHD related, indicate results of Conners' or similar ADHD ratings scales: ☐ Positive ☐ Inconclusive ☐ Negative ☐ N/A
3. Current Psychotropic Medications Prescribed: ☐ None ☐ Unknown	Dose: _____	Began: _____	Medications: _____

IX. CURRENT SUBSTANCE USE:

Is member actively abusing any substance? ☐ Yes ☐ No

If yes, elaborate: _____

X. REQUESTED TESTING:

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

Expected Start Date of Testing: _____

Names and Type(s) of Tests:	**Time Requested**: (Include Administration, Scoring, Interpretation and Reporting for EACH test)

******MAGELLAN STAFF ONLY******

To Be Completed by Magellan Psychologist

Authorized? ☐ Yes ☐ No Number of Hours: _____

Provider MIS #: _____

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: _____ _____

Licensed Psychologist Date

Comments: _____