Magellan HEALTHCARE℠

Psychological Testing
Preauthorization Request Form
Fax to Magellan: 1-866-848-4942

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 fax the completed form to: 1-866-848-4942.**

Please Print Clearly

Today's Date: _____

Patient's Name: _____ Patient's DOB: _____

Patient's Medicaid #: _____ Caseworker Name, if State Ward: _____

Person or Agency Making the Initial Request for Testing:

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

Testing Provider Information:

Name/Degree: _____ Telephone #: _____

Address: _____ Fax #: _____ Email: _____

Name of Agency/Organization: _____ MIS #: _____

Current or Provisional Diagnosis: _____

_____

_____

_____

_____

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

_____

_____

What are the current symptoms and/or functional impairments related to testing question?

_____

_____

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How would the results of testing affect the treatment plan? (Please be specific)

_____

_____

Medical/Psychological Evaluation and Treatment:

		Yes	No	
1.	Has the patient had a diagnostic interview (90791)?	☐	☐	If yes, date of interview: _____
2.	Has patient had an evaluation by a psychiatrist?	☐	☐	If yes, date of interview: _____
3.	Has patient had previous psychological testing?	☐	☐	Date: _____

Basic focus of previous psychological testing: _____

4. If current request is ADHD related, indicate latest results of Conners' or similar ADHD ratings scales:
   ☐ 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
   Dose: _____ Began: _____ Medication: _____
   Dose: _____ Began: _____ Medication: _____
   Dose: _____ Began: _____ Medication: _____

Current Substance Use:

Has member abused any substances in the last 30 days? ☐ No ☐ Yes *If yes, please elaborate:*

_____

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:

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