

Request for Authorization: Psychological Testing

Please submit this form electronically using our preferred method at <https://www.availity.com>.
This form can also be submitted via fax to 1-866-877-5229.

General information

Member name:			
Member date of birth:		Member ID #:	
Provider completing testing:			
Provider phone:		Provider fax:	
Provider ID or tax ID:		Provider NPI:	
Provider address:			
Provider email:			

Formal psychological testing is neither clinically indicated for routine screening or assessment of behavioral health disorders nor indicated for the administration of brief behavior rating scales and inventories. **Such scales and inventories are an expected part of a routine and complete diagnostic assessment.** Other than in exceptional cases, a diagnostic interview and relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization.

Requests for placement purposes and forensic purposes are not covered benefits. Requests for educational testing or learning disabilities assessment for educational purposes should be referred to the public school system.

Clinical assessment

Indicate which of the following assessments have been completed.

<input type="checkbox"/> Brief inventories and/or rating scales	<input type="checkbox"/> Interview with family members
<input type="checkbox"/> Clinical interview with patient	<input type="checkbox"/> Medical evaluation
<input type="checkbox"/> Consultation with patient's physician	<input type="checkbox"/> Psychiatric and medical history
<input type="checkbox"/> Consultation with school/other important persons	<input type="checkbox"/> Review of academic records/Individualized education plan (IEP)
<input type="checkbox"/> Direct observation of parent-child interactions	<input type="checkbox"/> Review of medical records
<input type="checkbox"/> Family history pertinent to testing request	<input type="checkbox"/> Structured developmental and social history

* Availity, LLC is an independent company providing administrative support services on behalf of Dell Children's Health Plan.

Clinical information

Indicate which of the following problems and symptoms presented a need for testing.

<input type="checkbox"/> Acting out behavior	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Low motivation
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Other developmental delays
<input type="checkbox"/> Attention seeking	<input type="checkbox"/> Inattention	<input type="checkbox"/> Poor attention span
<input type="checkbox"/> Delusions	<input type="checkbox"/> Irritability	<input type="checkbox"/> Speech and language delays
<input type="checkbox"/> Depression	<input type="checkbox"/> Labile mood	<input type="checkbox"/> Suicidal or homicidal ideation
<input type="checkbox"/> Disorganization	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Violence or physical aggression
<input type="checkbox"/> Distractibility	<input type="checkbox"/> Low frustration tolerance	<input type="checkbox"/> Other (Use space below for other.)
Other:		
Please attach any relevant medical records and/or clinical diagnostic assessment to support the request for testing.		
Duration of symptoms:		
<input type="checkbox"/> 0 to 3 months	<input type="checkbox"/> 3 to 6 months	<input type="checkbox"/> 6 to 9 months
<input type="checkbox"/> 9 to 12 months	<input type="checkbox"/> Greater than 12 months	

Treatment history

Please provide information regarding treatment history.

	Frequency	How long has member been in treatment?	Is member still in treatment?	Have symptoms improved?
Individual therapy:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication management:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
School- or home-based management:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other services:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of diagnostic interview:				

Rating scales

Please indicate which rating scales have been administered as part of your clinical assessment.

<input type="checkbox"/> Achenbach	<input type="checkbox"/> BASC	<input type="checkbox"/> CBCL	<input type="checkbox"/> MASC	<input type="checkbox"/> RAD
<input type="checkbox"/> ADHD rating	<input type="checkbox"/> BDI	<input type="checkbox"/> CDI	<input type="checkbox"/> MDQ	<input type="checkbox"/> STAI
<input type="checkbox"/> BA	<input type="checkbox"/> Brief	<input type="checkbox"/> Conner's	<input type="checkbox"/> PCL-5	<input type="checkbox"/> TSCC
<input type="checkbox"/> Other:				
Please note pertinent results of rating scales:				

Total units requested:		Total time requested:	
Provider signature:			
Date:			

For Dell Children's Health Plan use only:					
Date received:		Authorization from:			
Reference #:		Authorization to:			
	hours		hours		hours