dell children's HEALTH PLAN

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 **1-844-442-8011**.

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 is it 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.

☐ Brief inventories and/or rating scales	☐ Interview with family members
☐ Clinical interview with patient	☐ Medical evaluation
☐ Consultation with patient's physician	☐ Psychiatric and medical history
☐ Consultation with school/other important persons	☐ Review of academic records/IEP
	☐ Review of medical records
☐ Direct observation of parent-child interactions	☐ Structured developmental and social history
☐ Family history pertinent to testing request	

* 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.

☐ Acting out behavior	☐ Hallucinations	☐ Low motivation
☐ Anxiety	☐ Impulsivity	☐ Other developmental delays
☐ Attention seeking	☐ Inattention	☐ Poor attention span
☐ Delusions	☐ Irritability	☐ Speech and language delays
☐ Depression	☐ Labile mood	☐ Suicidal or homicidal ideation
☐ Disorganization	☐ Lethargy	☐ Violence or physical aggression
☐ Distractibility	☐ Low frustration tolerance	☐ 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:	☐ 0-3 months	☐ 3-6 months	☐ 6-9 months
	☐ 9-12 months	☐ 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:			☐ Yes ☐ No	☐ Yes ☐ No
Medication management:			☐ Yes ☐ No	☐ Yes ☐ No
School- or home-based management:			☐ Yes ☐ No	☐ Yes ☐ No
Other services:			☐ Yes ☐ No	☐ Yes ☐ No
Date of diagnostic interview:				

Rating scales

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

☐ Achenbach	☐ BASC	☐ CBCL	☐ MASC	☐ RAD
☐ ADHD rating	☐ BDI	☐ CDI	☐ MDQ	☐ STAI
☐ BA	☐ Brief	☐ Conner's	☐ PCL-5	☐ TSCC

☐ Other:
Please note pertinent results of rating scales:

Other pertinent information

Please include any other information that supports the request for psychological testing.

Previous psychological testing

Please include any information regarding previous psychological testing (such as dates of testing or results) and why retesting is requested.

ICD-10 diagnoses under evaluation

Please describe the rationale for testing. What are the current questions to be answered that cannot be addressed by the clinical interview, review of records and rating scales that you have already administered? How will the results of testing impact the course of treatment?

Is this a request for a trauma assessment? ☐ Yes ☐ No

Psychological tests and services requested

CPT® code(s)	Units requested	Test names/service description

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**