



PSYCHOLOGICAL TESTING PREAUTHORIZATION REQUEST

DATE	INSURED'S EMPLOYER		
PATIENT LAST NAME	FIRST NAME	DATE OF BIRTH	AGE
REFERRED BY		PHONE NUMBER	

PREVIOUS PSYCHOLOGICAL TESTING? Yes <input type="checkbox"/> No <input type="checkbox"/>	PSYCHIATRIC EVALUATION? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, list the date completed:	If Yes, list the date completed:

PROVIDER INFORMATION:			
PROVIDER NAME	OFFICE CONTACT PERSON	PHONE	FAX
NAME/LICENSURE OF PERSON ADMINISTERING PSYCHOLOGICAL TESTS		HAVE YOU COMPLETED A CLINICAL ASSESSMENT OF THE PATIENT? Yes <input type="checkbox"/> No <input type="checkbox"/>	

DSM-5 DIAGNOSIS:	OTHER DIAGNOSES UNDER CONSIDERATION:
_____	_____
_____	_____
_____	_____
_____	_____

SPECIFY ALL DIAGNOSTIC AND/OR CLINICAL QUESTIONS TO BE ANSWERED:

CURRENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST:
LIST EACH TEST USING THE COMPLETE NAME. TESTING TIME MUST BE ONLY TIME SPENT DIRECTLY WITH THE PATIENT.

TESTS:	TESTING TIME:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
TOTAL TESTING TIME _____	

Provider Signature _____
Date