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 ○ No ○

If Yes, list the date completed:

PSYCHIATRIC EVALUATION? Yes ○ No ○

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 ○ No ○

DSM-5 DIAGNOSIS:

OTHER DIAGNOSES UNDER CONSIDERATION:

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

CURRENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST:

THE REQUEST SHOULD INCLUDE TIME FOR ADMINISTRATION, SCORING, INTERPRETATION AND REPORTING. BRIEF RATING SCALES, SCREENING TOOLS, AND QUESTIONNAIRES ARE CONSIDERED INCIDENTAL TO THE PROFESSIONAL VISIT AND SHOULD NOT BE BILLED SEPARATELY. PLEASE ADD ADDITIONAL CODES IF THE REQUESTED CODE IS NOT SHOWN.

COMPLETE TEST NAME	PURPOSE OF TEST	PROCEDURE CODE AND UNITS					
		CODE	UNITS	CODE	UNITS	CODE	UNITS
		96130		96136		96146	
		96131		96137			
		96132		96138			
		96133		96139			
		CODE	UNITS	CODE	UNITS	CODE	UNITS
		96130		96136		96146	
		96131		96137			
		96132		96138			
		96133		96139			
		CODE	UNITS	CODE	UNITS	CODE	UNITS
		96130		96136		96146	
		96131		96137			
		96132		96138			
		96133		96139			

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		96131		96137			
		96132		96138			
		96133		96139			

Total Units Requested ____________

Total Hours Requested ____________

____ ______________

Provider Signature **Date**