AmeriHealth Caritas Louisiana

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Behavioral Health Psychological/Neuropsychology Testing Request Form

Please print clearly — incomplete or illegible forms will delay processing.
Submit to: Behavioral health utilization management
Fax: **1-855-301-5356**
For assistance please call **1-855-285-7466**

Member information		
Patient name:	Health plan:	Date of birth:
Social security #:	Patient ID or MAID ID #:	Referral source:

Provider information		
(Please indicate by checking below, whether requested services should be authorized to the provider or agency.)		
❑ Provider ❑ Group/agency Name:_____	Provider credential: ❑ MD ❑ PhD ❑ Other, please specify:_____	
Physical address:	Telephone number:	Fax number:
Medicaid/TPI/NPI #:	Tax ID #:	

Referral reason/question
Testing will not be authorized under any of the following conditions: 1. Testing is primarily for educational or vocational purposes. 2. Testing is primarily for legal purposes. 3. The tests requested are experimental or have no documented validity. 4. The time requested to administer the testing exceeds established time parameters. 5. Testing is routine for entrance into a treatment program.
Is this testing required for educational purposes, behavioral health purposes, or both? Explain:
State how the anticipated results of the testing will affect the patient's treatment plan:

DSM IV Axis		
Axis I	R/O	R/O
Axis II		
Axis III		
Axis IV		
Axis V	Current	Past year

Danger to self or others? ❑ Yes ❑ No
If yes, please explain:

MSE within normal limits? ❑ Yes ❑ No
If no, please explain:

List current medications:

Name/strength	Directions

What are the current symptoms prompting the request for testing?

- ❑ Anxiety
- ❑ Depression
- ❑ Inattention
- ❑ Confusion
- ❑ Hypo-activity
- ❑ Hyperactivity
- ❑ Psychosis/hallucinations
- ❑ Bizarre behavior
- ❑ Unprovoked agitation/ aggression
- ❑ Self-injurious behavior eating
- ❑ Disorder symptoms
- ❑ Withdraw/poor social interaction
- ❑ Mood instability
- ❑ Changes in memory capacity
- ❑ Changes in cognitive capacity
- ❑ Behavior problems affecting life functions (e.g., school, home) poor academic performance
- ❑ Other, list:

Comments/explain:

Was a behavioral health/substance abuse evaluation completed?

❑ Yes ❑ No Date:_____

Results and attach all relevant clinical information to request:

Was previous psychological or neuropsychological testing conducted?

❑ Yes ❑ No Date:_____

Basic focus and results:

History

When was the patient's last physical examination?_____

If ADHD is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available:

❑ Positive ❑ Negative ❑ Inconclusive ❑ Not applicable

Comment/explain:

Treatment Request

Start date MM/DD/YY	Stop date MM/DD/YY	CPT code	Modifier(s)	Units requested

Please list the tests planned to answer the clinical questions:				
Test	Reason for use	Educational Yes/No	Number of units requested for test	Number of units approved for test
Indicate the total number of units (hours) requested:_____				

Provider signature:_____ Date:_____