

Behavioral Health Service Request Form

Psychological and Neuropsychological Testing
Please submit to the Dedicated Contract Fax Line Below

Florida Medicaid

Fax 855-713-0587

Place of Service	<input type="checkbox"/> 11- Office Center <input type="checkbox"/> 12- Home <input type="checkbox"/> 22- Outpatient Hospital <input type="checkbox"/> 31- Skilled Nursing Facility <input type="checkbox"/> 53- Community Mental Health			
Service Request Start Date:	Is this a post service request? <input type="checkbox"/> Yes <input type="checkbox"/> No			

MEMBER INFORMATION

Last Name	First Name, Middle Initial	Date of Birth	
Phone Number	WellCare ID Number	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Third Party Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type, and number.		Languages Spoken

TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name	First Name	NPI Number	
WellCare ID Number	Participating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discipline/Specialty
Street Address	City, State	ZIP	
Phone Number	Fax Number	Office Contact	

FACILITY/AGENCY INFORMATION

Name	Facility ID	NPI Number	
Street Address	City, State	ZIP	
Phone Number	Fax Number	Office Contact	

Service Type Requested	List CPT Code(s)	List the Specific Tests/Scales Required	Units/Hours Requested per Test
Psychological Testing			
Neuropsychological Testing			

Total number of hours requested for all tests: _____

DIAGNOSIS – Code and Description

Primary Diagnoses	
Secondary Diagnoses	
Medical Problems	

Are services requested court ordered? Yes No *If yes, please submit a copy of the court order and all supporting documentation.*

SYMPTOMS/FUNCTIONAL IMPAIRMENTS OF CONCERN

What are the symptoms/functional impairments of concern?

Attach additional notes or a copy of diagnostic interview if needed

TESTING RESULTS ACTION *Required***

How will the testing results impact the decision regarding treatment options?

RATIONALE FOR REQUEST

Testing referral source:

<input type="checkbox"/>	Court/DJJ**	<input type="checkbox"/>	Psychologist
<input type="checkbox"/>	Parent	<input type="checkbox"/>	School
<input type="checkbox"/>	PCP	<input type="checkbox"/>	State Agency
<input type="checkbox"/>	Psychiatrist	<input type="checkbox"/>	Other (Please specify)

What is the overall clinical question that needs to be answered by the requested testing?

Has the member had an evaluation by a psychiatrist? If so, by whom and when? If not, why not?

Has the member had a diagnostic interview? If yes, date of interview? Name and credentials of provider who completed the interview?

Why can't the questions at hand be answered by the diagnostic interview, a review of the member's record, or a second opinion instead of testing?

Has the member had testing before? If so, by whom and when?

PREVIOUS TREATMENT

Type	Frequency	Duration	Provider (if known)

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Adherent?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

