

Behavioral Health Service Request Form

Psychological and Neuropsychological Testing

Please Submit to the Dedicated Fax Line Below

Georgia Medicaid

1-888-871-0590

Place of Service	<input type="checkbox"/> 11- Office <input type="checkbox"/> 22- Outpatient Hospital <input type="checkbox"/> 53- Community Mental Health Center <input type="checkbox"/> Other: <i>(Indicate here)</i>		
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, please 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	

Are all units exhausted? Yes No If No, indicate amount used:

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 Diagnosis	
Secondary Diagnosis	
Medical Problems	

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

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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, please state date of interview? Please provide the 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?			
Psychological testing will be administered by provider whose qualifications are appropriate to proposed assessment. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Who will the information obtained from the testing be shared with for coordination of care?			
Will the member's family/support system (teacher; caregiver) be engaged in the testing or treatment indications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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



WellCare proudly serves the Georgia Medicaid and PeachCare for Kids® members enrolled in the Georgia Families® program and women enrolled in the Planning for Healthy Babies® program.