

Behavioral Health Service Request Form

Psychological and Neuropsychological Testing

Please Submit to the Dedicated Fax Line Below
Georgia Medicare
Medicare Only Members: 1-877-892-8213
Dual Eligible Members (Members with Medicare & Medicaid Policies): 1-855-292-0233
Discharge Planning: 1-855-776-9464

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, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, indicate amount used:
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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:	
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DIAGNOSIS – Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnoses	

Are the services requested court-ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please submit a copy of the court order and all supporting documentation.</i>

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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.	
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TESTING RESULTS ACTION *Required*

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

Psychological testing will be administered by provider whose qualifications are appropriate to proposed assessment. Yes No

Who will the information obtained from the testing being shared with for coordination of care?

Will the member's family/support system (teacher; caregiver) be engaged in the testing or treatment indications? Yes 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