Behavioral Health Service Request Form

Psychological and Neuropsychological Testing

Medicare

Please submit to the dedicated fax line below.	
Arizona: **1-855-713-0593**	Kentucky: **1-888-365-5676**
Florida: **1-855-710-0168**	New Jersey: **1-888-339-2677**
Hawaii: **1-888-881-8225**	New York: **1-855-713-0589**
Connecticut, Maine, North Carolina: **1-888-365-5607**	Texas: **1-855-671-0259**
Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: **1-855-710-0160**	
Illinois, Iowa, Michigan, Missouri, Washington: **1-855-713-0593**	
Georgia: Medicare Only Members **1-877-892-8213**, Dual Eligible Members **1-855-292-0233**	
Place of Service: ☐ 11-Office ☐ 22-Outpatient Hospital ☐ 53-Community Mental Health Center ☐ Other:	
Service Request Start Date:	Is this a post-service request? ☐ Yes ☐ No

Member Information

Last Name:	First Name, Middle Initial:	Date of Birth:
Phone Number:	Wellcare ID Number:	Gender: ☐ Male ☐ Female

Third-Party Insurance: ☐ Yes ☐ 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: ☐ Yes ☐ 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:

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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:			

Diagnosis – Code and Description

Primary diagnosis:

Secondary diagnosis:

Medical diagnoses:

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 affect the decision regarding treatment options?

Rationale for Request

Testing referral source:

☐ Court/DJJ ☐ Parent ☐ PCP ☐ Psychiatrist ☐ Psychologist
☐ School ☐ State Agency ☐ 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? ☐ Yes ☐ No If so, by whom and when? If not, why not?

Has the member had a diagnostic interview? ☐ Yes ☐ No
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? ☐ Yes ☐ No If so, by who 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

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Previous Treatment

Type	Frequency	Duration	Provider (if known)

Current Medications (Psychotropic and Medical)

Medication	Dosage	Frequency	Adherent?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No