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	☐ 11- Office ☐ 12- Home ☐ 22- Outpatient Hospital ☐ 31- Skilled Nursing Facility ☐ 53- Community Mental Health Center
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	

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.*

©WellCare 2016 FL_05_16

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:			
☐	**Court/DJJ****	☐	**Psychologist**
☐	**Parent**	☐	**School**
☐	**PCP**	☐	**State Agency**
☐	**Psychiatrist**	☐	**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?**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**