Behavioral Health Service Request Form

Psychological and Neuropsychological Testing

<Please Submit to the Dedicated Contract Fax Line Below>

Medicare			Medicaid
Arizona- 888-834-8404	**Kentucky-**888-365-5676	**Ohio-** 855-710-0164	**Georgia-**888-871-0590
Arkansas – 855-710-0160	**Louisiana-** 855-710-0160	**South Carolina -** 855-710-0160	**Kentucky-**877-544-2007
Connecticut- 888-365-5607	**Mississippi** - 855-710-0160	**Tennessee -** 855-710-0160	**Illinois-** 855-713-0595
Florida- 855-710-0168	**Missouri-** 855-710-0162	**Texas-** 855-671-0259	**New Jersey-**888-339-2677
Georgia-855-710-0166	**New Jersey-**888-339-2677		**New York-** 855-713-0591
Illinois-855-713-0593	**New York-** 855-713-0589		

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan fourteen (14) days prior to the date the requested services will be performed.
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request _____ Date Signed _____

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)and Number of Each Requested*	*List the Specific Tests/Scales Required*
Psychological Testing		
Neuropsychological Testing		

Service Request Start Date:

DSM-IV DIAGNOSIS (AXIS I – V)

Primary Diagnoses		**R/O**	
Secondary Diagnoses		**R/O**	
Medical Problems			

Current GAF/CAFAS		**Highest GAF/CAFAS in Past Year**	

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Current Total LOCUS/CALOCUS Score: (if applicable)		**Current ASAM Dimension Scores: (if applicable)**	

RATIONALE FOR REQUEST			
Who initiated the testing request:			
☐	**Court**	☐	**Psychiatrist**
☐	**DJJ**	☐	**Psychologist**
☐	**Parent**	☐	**School**
☐	**PCP**	☐	**State Agency**
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 so, by whom and when?			
Has the member had testing before? If so, by whom and when?			
If testing has been done previously please list the instruments and result?			
Why can't the questions at hand be answered by a diagnostic interview, a review of the member's record, or a second opinion instead of testing?			
Is the testing associated with a DX or potential DX of ADHD? If so, indicate the latest Conner's or similar ADHD ratings scales.			
Is substance use a factor? If so, describe			

CURRENT MEDICATIONS (Psychotropic and Medical)			
Medication	**Dosage**	**Frequency**	**Adherent?**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
Any medication contraindications? If yes, describe.			