WellCare Beyond Healthcare. A Better You. OHANA HEALTH PLAN WellCare | TexanPlus

Behavioral Health Service Request Form

Psychological and Neuropsychological Testing

Please Submit to the Dedicated Fax Line Below	
Medicare	
Arizona 1-866-246-9832 Arkansas 1-855-710-0160 Connecticut 1-888-365-3233 Florida 1-855-710-0167 Georgia 1-855-710-0165 Hawaii 1-888-881-8225 Illinois 1-855-713-0592 Kentucky 1-888-365-5615 Louisiana 1-855-710-0160	Maine 1-888-365-5607 Mississippi 1-855-710-0160 New Jersey 1-855-703-8082 New York 1-855-713-0588 North Carolina 1-888-365-5607 South Carolina 1-855-710-0160 Tennessee 1-855-710-0160 Texas 1-855-671-0258

Place of Service	☐ 11- Office ☐ 22- Outpatient Hospital ☐ 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 Diagnosis	
Secondary Diagnosis	

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Medical Problems	
Are the 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 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 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?

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			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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