



# Behavioral Health Service Request Form

Psychological and Neuropsychological Testing  
Please submit to the Dedicated Contract Fax Line Below

**New York Medicaid**

Fax 855-713-0591

Place of Service	<input type="checkbox"/> 11- Office Center <input type="checkbox"/> 12- Home <input type="checkbox"/> 22- Outpatient Hospital <input type="checkbox"/> 31- Skilled Nursing Facility <input type="checkbox"/> 53- Community Mental Health			
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	

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 requested services 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 :**

<input type="checkbox"/>	<b>Court / DJJ**</b>	<input type="checkbox"/>	<b>Psychologist</b>
<input type="checkbox"/>	<b>Parent</b>	<input type="checkbox"/>	<b>School</b>
<input type="checkbox"/>	<b>PCP</b>	<input type="checkbox"/>	<b>State Agency</b>
<input type="checkbox"/>	<b>Psychiatrist</b>	<input type="checkbox"/>	<b>Other (Please specify)</b>

**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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No