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	☐ 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 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 :

☐	**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