REQUEST FOR NON-PARTICIPATING PROVIDER PSYCHOLOGICAL TESTING PREAUTHORIZATION

Contracted providers should utilize the Online Authorization System. This form should be utilized for Out of Network Providers. (This includes contracted providers where the member is eligible in a county in which you are not contracted)

The testing provider must complete Section XI, *Requested Testing* and, if applicable, Section XIII, *Technician Attestation*. Either the referring provider or the testing provider may complete other sections of the form. Please provide all requested information, subject to applicable law. In most cases, an initial assessment by a behavioral healthcare provider must be administered before psychological testing will be authorized.

Authorization for psychological testing will not be considered until all sections of this form are completed. To avoid potential issues with reimbursement, psychological testing should not be initiated until an authorization has been received.

Out-of-network provider: Fax this completed form to **Magellan Healthcare** at 866-667-7744.

Please print clearly – Complete all items – Incomplete forms cannot be processed

☐ I attest that I am completing this form as a non-participating provider.

Participating (actively contracted for PA HealthChoices Medicaid) providers will need to complete the request through the Online Authorization System: Provider Announcement

I.

Today's Date: _____ Requested Start Date of Authorization: _____

Member Name: _____ MA ID #: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Member County:

☐ Bedford ☐ Bucks ☐ Cambria ☐ Lehigh ☐ Montgomery ☐ Northampton ☐ Somerset

II. Rationale for Non-Par Request:

☐	No in-network / participating provider resources within 30 Miles. A search for in-network / providers will be conducted by Magellan for this option.
☐	By checking this box, I attest that I have reviewed each of the criteria below and that this non-par request is in compliance with the following:
•	It is expected that an initial diagnostic evaluation or initial office visit with E/M services has already been completed. Please attach the diagnostic evaluation (90791 – no medical services) or (90792 – with medical services) OR initial office visit with E/M services (99203, 99204, 99205) with your request.
•	If testing for diagnosis Attention-Deficit Hyperactive Disorder (ADHD) is being requested, please attach the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales that are inconclusive.

III. Person or Agency making the *Initial* Referral to the Testing Psychologist:

☐ Psychiatrist ☐ Other Psychologist ☐ School Staff (Specify): _____

☐ Psychotherapist ☐ Parent ☐ PCP/Medical Specialist: _____

☐ Testing Psychologist ☐ Court ☐ Other: _____

IV. Testing Provider Information:

Name of Person Completing Service: _____ Degree: _____

Telephone Number with extension: _____ Fax Number: _____

E-mail address: _____

Name of Agency / Org / Group: _____

Service Address: Street: _____ City: _____ State: _____ Zip: _____

NPI #: _____ Tax ID #: _____ Tax ID Owner Name: _____

Group MA #: _____ Testing Practitioner MA #: _____

V. Current or Provisional DSM-5 Diagnosis and ICD 10 Code:

Code: _____ ☐ Current ☐ Provisional Description: _____

Code: _____ ☐ Current ☐ Provisional Description: _____

Code: _____ ☐ Current ☐ Provisional Description: _____

(For the following questions, attach additional sheet if needed.)

VI. What is the clinical question to be answered by testing?

VII. Why can't this question be answered by a diagnostic interview, a medical and / or neurological consult, review of psychological / psychiatric records, or a second opinion?

VIII. What are the current symptoms and / or functional impairments related to testing question?

IX. How would the results of testing affect the treatment plan (be specific)? (*This item is not applicable in New Jersey*)

X. Medical / Psychological Evaluation and Treatment:

1. Has patient had an evaluation by a psychiatrist within the last 6 months? ☐ Yes ☐ No If yes, date: _____
2. Has patient had previous psychological testing within the last year? ☐ Yes ☐ No If yes, date: _____ Area of Focus: _____
3. Current psychotropic medications (including dose and begin date): _____

☐ None ☐ Unknown

XI. Current Substance Use:

Has member used any substance in the last 30 days? ☐ Yes ☐ No

If yes, elaborate: _____

XII. Requested Testing: (This section must be completed by the testing psychologist)

Names and Type(s) of Tests:

(To avoid confusion or processing delays, please print clearly and **be precise** when listing test names / acronyms)

USE ONLY APPROVED CODES BELOW IN SECTION XII

XIII. Magellan CPT® Codes for Psychological and Neuropsychological Testing Services

CPT® Codes and Descriptions[1] *For services rendered on or after Jan. 1, 2019*	**CPT Codes and Number of Requested Units**
96130 Psychological testing evaluation services by physician or other QHP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s) when performed, **first hour**	_____ **unit** *(Only one unit of one hour allowed)*
+96131 Psychological testing evaluation services, by physician or other QHP, each additional hour	_____ **# of additional hours**
96132 Neuropsychological testing evaluation services by physician or other QHP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s) when performed, **first hour**	_____ **unit** *(Only one unit of one hour allowed)*
+96133 Neuropsychological testing evaluation services by physician or other QHP, each additional hour	_____ **# of additional hours**
96136 Psychological or neuropsychological test admin and scoring by physician or other QHP, two or more tests, any method, first 30 minutes	_____ **unit** *(Only one unit of 30 minutes allowed)*
+96137 Psychological or neuropsychological test admin and scoring by physician or other QHP, two or more tests, any method, each additional 30 minutes	_____ **unit(s)** *(# of additional units of 30 minutes each)*
Total number of units requested (count automated test admin as one hour):	_____ **units**

Please note: Codes on reimbursement schedules may vary by state or plan. Nothing in this document should be construed as altering your currently contracted services. There may be codes above for which you are not contracted. The presence of them here does not add them to your current contract.

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Name/degree: _____