REQUEST FOR PSYCHOLOGICAL TESTING PREAUTHORIZATION

Either the provider making the referral for psychological testing or the provider conducting the testing must complete this form; however, the completed form must be reviewed and approved by the testing provider. Please provide all requested information, subject to applicable law. In most cases, an initial assessment by a behavioral health care 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 is not to be initiated until an authorization has been received.

Please fax the completed form to the respective care manager at 1-866-667-7744.

PLEASE TYPE OR PRINT CLEARLY

I. TODAY'S DATE: ________________________
Member Name: __________________________
Insurance Plan: _________________________
DOB: ________________________
Subscriber ID (If different from Member): ________________________
MA ID #: __________________________

II. PERSON OR AGENCY MAKING REQUEST FOR TESTING:
☐ Psychologist
☐ Psychiatrist
☐ Psychotherapist
☐ Court
☐ Parent
☐ Teacher
☐ School Staff (Specify): ________________________
☐ PCP/Medical Specialist: ________________________
☐ Other: ______________________________________

III. REFERRING PROVIDER INFORMATION: TESTING PROVIDER INFORMATION:
Name/Degree: ____________________________
Address: ________________________________
Telephone #: ____________________________
Fax #: ____________________________
E-mail: ________________________________

IV. CURRENT OR PROVISIONAL DSM-5 DIAGNOSIS and ICD 10 Code:
________________________________________
________________________________________
________________________________________

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

V. What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records, or second opinion?

________________________________________
________________________________________
________________________________________
________________________________________

VI. What are the current symptoms related to this question?

________________________________________
________________________________________
________________________________________
________________________________________

VII. How would the results of testing affect the treatment plan?

________________________________________
________________________________________
________________________________________
________________________________________
### VIII. MEDICAL/PSYCHOLOGICAL EVALUATION AND TREATMENT:

<table>
<thead>
<tr>
<th>1. Has client had a diagnostic interview (90791 or 90792)? Psychiatrist Evaluation?</th>
<th>Yes</th>
<th>No</th>
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<td>If yes, date of interview: ___________________________________</td>
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<td>If yes, date of interview: ___________________________________</td>
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| 2. Previous Psychological Testing? Date? Basic Focus: |
|---------------------------------------------------|----------------|----------------|
|                                                   | ☐              | ☐              |
| If ADHD related, indicate results of Conners’ or similar ADHD ratings scales: |
| □ Positive                                       | □ Inconclusive | □ Negative     |
| □ N/A                                            |                |                |

| 3. Current Psychotropic Medications Prescribed: |
|------------------------------------------------|--------|
| Dose: Began: Medications:                       |        |
| ☐ None ☐ Unknown                                |        |

### IX. CURRENT SUBSTANCE USE:

Is member actively abusing any substance? ☐ Yes ☐ No
If yes, elaborate: __________________________________________

### X. REQUESTED TESTING:

Number of hours requested (total): __________________ Is testing primarily neuropsychological? ☐ Yes ☐ No
Expected Start Date of Testing: ____________________________

**Names and Type(s) of Tests:**

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<thead>
<tr>
<th>Names and Type(s) of Tests:</th>
<th>Time Requested:</th>
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**MAGELLAN STAFF ONLY****

To Be Completed by Magellan Psychologist

Authorized? ☐ Yes ☐ No Number of Hours: ____________
Provider MIS #: ___________________________________

Explain your decision in Comments section below.

If approved and provider needs ad hoc, send in ad hoc completed form. Certification #: _______________________
An authorization can be issued only after ad hoc is approved.

Name/degree: __________________________________________ Date

Comments: _________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
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______________________________________________________________________________________________