



Request for Psychological Testing

DATE \_\_\_ / \_\_\_ / \_\_\_

MEMBER NAME \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_

MEDICAID # \_\_\_\_\_ OUTPATIENT  INPATIENT

Virginia Premier Health Plan views psychological testing as a specialized component of the clinical assessment process. It is authorized under the mental health benefit via a two-(2) step process:

- 1. The treatment provider or the Primary Care Physician initiates a recommendation for one (1) hour consultation by the psychologist to evaluate the patient's need for testing and to complete this form.
2. Actual psychological testing must await direct pre-authorization by Virginia Premier Health Plan.

Psychological testing is to be done only when data necessary for diagnosis and/or treatment planning is unavailable by other means of assessment (i.e. clinical interviews, relevant history, application of DSM-IV criteria, structured checklists, consultation with other treatment providers, review of records and interviews with parents, teachers, and significant others, etc.)

TREATING PROVIDER/REFERRING CLINICIAN COMPLETES THIS SECTION

1. Name and Credentials: \_\_\_\_\_ (Please print) Phone # ( )
\_\_\_\_\_  
(Signature) Fax # ( )

2. Patient's Current Symptoms, Relevant Treatment and Medication History:
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. DSM-IV Diagnoses: Axis I \_\_\_\_\_ (DX and code#) Axis II \_\_\_\_\_ (DX and code#)

4. Referral Question(s) (Please list the specific clinical question(s) to be addressed by psychological testing):
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. List all that has been done to answer these clinical question(s) prior to requesting psychological testing. (Please note any previous psychological testing, with dates and results):
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. How will requested psychological testing facilitate patient's treatment?:
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TESTING PSYCHOLOGIST COMPLETES THIS SECTION:

(Check One (1): Psych Testing  or Neuropsych Testing

1. Name and Credentials: \_\_\_\_\_ (Please print) Phone # ( )
\_\_\_\_\_  
(Signature) Fax # ( )

Table with 4 columns: Test(s) requested, Time requested, Test(s) requested, Time requested. Rows A, B, C, D, E, F.

Total time requested: \_\_\_\_\_

Proposed Date of Testing: \_\_\_\_\_