



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: _____ Phone # (____) _____
 (Please print)
 _____ Fax # (____) _____
 (Signature)

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

3. DSM-IV Diagnoses: Axis I _____ Axis II _____
 (DX and code#) (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: _____ Phone # (____) _____
 (Please print)
 _____ Fax # (____) _____
 (Signature)

Test(s) requested	Time requested	Test(s) requested	Time requested
A.		D.	
B.		E.	
C.		F.	

Total time requested: _____

Proposed Date of Testing: _____