YouthCare
HealthChoice Illinois

SUBMIT TO: Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
Phone 1.855.745.5507 I Fax 1.844.273.2331

Psychological or Neuropsych Testing Authorization Request Form

*All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.

Please indicate which level of care the member is currently engaged: ❍ **Inpatient** ❍ **Outpatient**

IDENTIFYING INFORMATION

Member Name _____ DOB _____ SSN _____

Member ID # _____ Provider Name _____

Provider Name _____ OR Agency/Group Name _____

Professional Credentials _____

Provider Phone # _____ Fax # _____

Address (street/city/state) _____

NPI # _____ Tax ID # _____

Referral Source _____

DIAGNOSIS (Please report all diagnoses being considered for this member)

Primary (Required) _____ R/O _____ R/O _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Danger to Self or Others (If yes, please explain)? ❍ Yes ❍ No _____

MSE Within Normal Limits (If no, please explain)? ❍ Yes ❍ No _____

WHAT ARE THE CURRENT SYMPTOMS PROMPTING THE REQUEST FOR TESTING?

- ❍ Anxiety
- ❍ Depression
- ❍ Withdrawn/poor social interaction
- ❍ Mood instability
- ❍ Psychosis/ Hallucinations
- ❍ Inexplicable Behavior
- ❍ Unprovoked agitation/ aggression
- ❍ Self-injurious Behavior
- ❍ Eating disorder symptoms
- ❍ Poor academic performance
- ❍ Behavior problems at home
- ❍ Behavior problems at school
- ❍ Inattention
- ❍ Hyperactivity
- ❍ Other _____

What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing affect the care and treatment in a meaningful way?

_____

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MEMBER HISTORY

Does the patient have any significant medical illnesses, history of developmental problems,head injuries or seizures in the past? ❍ Yes ❍ No

Comments _____

Does the patient have a family history of psychiatric disorders, behavior problems or substance use?

❍ Yes ❍ No ❍ Uncertain

Comments _____

Is there any known or suspected history of physical or sexual abuse or neglect?

❍ Yes ❍ No ❍ Uncertain

Comments _____

If ADHD is a diagnostic rule out, please complete the following: Is the patient's presentation on intake consistent with ADHD? ❍ Yes ❍ No

Indicate the results of Conner's or similar ADHS rating scales, if given:

❍ Positive ❍ Negative ❍ Inconclusive ❍ N/A

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (i.e., teacher feedback, results of school standardized testing)

_____

Date of Diagnostic Interview _____

Has the patient had a Psychiatric Evaluation? ❍ Yes ❍ No If yes, date of the interview _____

Previous Psychological Testing? ❍ Yes ❍ No If yes, date? _____

Basic Focus and Results _____

CURRENT PSYCHOTROPIC MEDICATIONS

Prescriber: ❍ Psychiatrist ❍ General Practitioner ❍ Other

Medication Name	Date Started	Compliant? (Y/N)

REQUEST FOR AUTHORIZATION

Please check only one code:

Psych/NeuroPsych Testing:

❍ 96116 ❍ 96121 ❍ 96130 ❍ 96131
❍ 96132 ❍ 96133 ❍ 96136 ❍ 96137
❍ 96138 ❍ 96139 ❍ 96146

Aphasia Assessment: ❍ 96105

Developmental Testing: ❍ 96112 ❍ 96113

Please list the tests planned to answer the clinical questions.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Number of units requested to complete tests:

_____

Provider Name _____

Provider Signature _____ Date _____

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).