Behavioral Health Service Request Form

Psychological and Neuropsychological Testing

Please Submit to the Dedicated Fax Line Below
Georgia Medicare
Medicare Only Members: 1-877-892-8213
Dual Eligible Members (Members with Medicare & Medicaid Policies): 1-855-292-0233
Discharge Planning: 1-855-776-9464

Place of Service	☐ **11- Office**	☐ **22- Outpatient Hospital**	☐ **53- Community Mental Health Center** ☐ **Other:**(*Indicate here*)
Service Request Start Date:		**Is this a post-service request?**	☐**Yes** ☐**No**

MEMBER INFORMATION					
Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**Wellcare ID Number**		**Gender**	☐**Male** ☐**Female**
Third Party Insurance	☐**Yes** ☐**No**	If **Yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.		**Languages Spoken**	

TREATING PROVIDER/PRACTITIONER INFORMATION					
Last Name		**First Name**		**NPI Number**	
Wellcare ID Number		**Participating**	☐**Yes** ☐**No**	**Discipline/Specialty**	
Street Address		**City, State**		**ZIP**	
Phone Number		**Fax Number**		**Office Contact**	

FACILITY/AGENCY INFORMATION					
Name		**Facility ID**		**NPI Number**	
Street Address		**City, State**		**ZIP**	
Phone Number		**Fax Number**		**Office Contact**	

Are all units exhausted? ☐ **Yes** ☐ **No**	**If No, indicate amount used:**

Service Type Requested	**List CPT Code(s)**	**List the Specific Tests/Scales Required**	**Units/Hours Requested per Test**
Psychological Testing			
Neuropsychological Testing			
Total number of hours requested for all tests:			

DIAGNOSIS – Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnoses	

Are the services requested court-ordered? ☐ **Yes** ☐ **No** ***If yes, please submit a copy of the court order and all supporting documentation.***

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SYMPTOMS/FUNCTIONAL IMPAIRMENTS OF CONCERN	
What are the symptoms/functional impairments of concern? **Attach additional notes or a copy of diagnostic interview if needed.**	

TESTING RESULTS ACTION ***Required**	
How will the testing results impact the decision regarding treatment options?	

RATIONALE FOR REQUEST

Testing referral source:

☐	**Court/DJJ**	☐	**Psychologist**
☐	**Parent**	☐	**School**
☐	**PCP**	☐	**State Agency**
☐	**Psychiatrist**	☐	**Other (Please specify)**

What is the overall clinical question to be answered by the requested testing?

Has the member had an evaluation by a psychiatrist? If so, by whom and when? If not, why not?

Has the member had a diagnostic interview? If yes, date of interview? Name and credentials of provider who completed the interview?

Why can't the questions at hand be answered by the diagnostic interview, a review of the member's record or a second opinion instead of testing?

Has the member had testing before? If so, by whom and when?

Psychological testing will be administered by provider whose qualifications are appropriate to proposed assessment. ☐**Yes** ☐**No**

Who will the information obtained from the testing being shared with for coordination of care?

Will the member's family/support system (teacher; caregiver) be engaged in the testing or treatment indications? ☐**Yes** ☐**No**

PREVIOUS TREATMENT

Type	Frequency	Duration	Provider (if known)

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Adherent?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No