FirstCare HEALTH PLANS

Psychological/Neuropsychological Testing Prior Authorization Request Form

SECTION I—Submission

Insurer Name: FirstCare Health Plans	**Phone:** 800.327.6943 **Fax:** 512.233.5949	**Date:**

SECTION II—General Information

Review Type: ☐ Non-Urgent ☐ Urgent	**Clinical Reason for Urgency:**
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment	**Previous. Auth. #:**

SECTION III—Patient Information

Name:	**Phone:**	**DOB:**	**Sex:** Male☐ Female☐
Subscriber Name *(if different)*:	***Member or Medicaid ID #:**		**Group #:**

SECTION IV—Provider Information

Name:			
Individual NPI:	**TIN:**	**Group NPI:**	**TIN:**
Phone:		**Fax:**	
Address:			
Contact Name:			
Primary Care Physician Name:	**Phone (extension):**	**Fax:**	

SECTION V—Clinical Documentation (Attach supporting clinical documentation if needed.)

Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders. Psychological or psychiatric evaluations of patients with psychiatric disorders that may reasonably be completed through clinical interview and other routine assessment tools (eg, self-administered or self-scored evaluations (eg, Holmes and Rahe Social Readjustment Rating Scale) or screening cognitive tests (eg, Folstein Mini-Mental State Exam or Montreal Cognitive Assessment)) are considered standard evaluation and management services and are not categorized as psychological testing services.

Clinical Assessment—Indicate which of the following assessments have been completed:

☐ Psychiatric and medical history	☐ Clinical interview with patient	☐ Structured developmental and social history	☐ Direct observation of parent-child interactions
☐ Family history pertinent to testing request	☐ Interview with family members	☐ Consultation with school/ other important persons or agencies	☐ Medical evaluation
☐ Consultation with patient's physician	☐ Brief inventories and/ or rating scales	☐ Review of medical records	☐ Review of academic records/ IEP

Clinical Information—Indicate which of the following problems and symptoms presented a need for testing:

☐ Inattention	☐ Irritability	☐ Disorganization	☐ Depression	☐ Anxiety
☐ Labile mood	☐ Lethargy	☐ Low motivation	☐ Distractibility	☐ Impulsivity
☐ Poor attention span	☐ Acting out behavior	☐ Attention seeking	☐ Hallucinations	☐ Delusions
☐ Low frustration tolerance	☐ Suicidal/ homicidal ideation	☐ Violence/ physical aggression	☐ Speech and language delays	☐ Other developmental delays

Other Symptoms:
Duration of symptoms: ☐ 0-3 Mo. ☐ 3-6 Mo. ☐ 6-9 Mo. ☐ 9-12 Mo. ☐ <12 Mo.

SECTION V—Clinical Documentation (continued)

Proposed psychological testing can help answer questions that medical, neurologic, or psychiatric evaluation, diagnostic testing, observation, or other assessment cannot as evidenced by:
Recommended testing is necessary and information achieved by psychological testing is not attainable through routine medical, neurologic, or physical assessment as evidenced by:
Medications previously tried/ failed:
Medical Issues (including any known pregnancy/ birth complications, brain injury, head trauma, lead poisoning):
Current medications (psychiatric or medical):
Academic issues (if applicable):
History of substance use/ abuse: ☐ Y ☐ N Date of last use: If yes, what substance(s)?
Diagnosis(es):

If the primary diagnosis for testing is ADHD, indicate why the evaluation is not routine:

☐ Previous treatment(s) have failed and testing is required to reformulate the treatment plan

☐ A conclusive diagnosis was not determined by a standard examination

☐ And/ or specific deficits related to or co-existing with ADHD need to be further evaluated

☐ Other (please specify):

_____

_____

SECTION VI—CPT Codes Requested

CPT Codes Requested:	Units:
Inpatient ☐ Provider Office ☐ Other:_____	

Tests Requested:	Time to Administer and Score:

Dates Requested for Testing:		
From:	To:	Total Units Requested: