



PRECERTIFICATION FOR PSYCHOLOGICAL TESTING REQUEST

Member Name: _____ DOB: _____

ID#: _____ INSURANCE: CHIP _____ STAR _____

Current Diagnoses under evaluation

Axis 1 _____ Axis 2 _____ Axis 3 _____ Axis 4 _____ Axis 5 _____

1. Brief psychiatric history of patient (including previous psychiatric admissions):

2. Describe the results of treatment to date and the reason testing is indicated at this time.

3. Have resources for psychological evaluation through the patient's school been explored?
 YES _____ NO _____ Explain: _____

4. Which area(s) most appropriately describe(s) the current questions to be addressed by testing?

<u>Clinical Questions</u>	<u>Specific Test(s) Planned</u>	<u>Tests Approved</u> (Office Use Only)
a. Organic/neuro psychological factors related to disturbances in functioning	_____	_____
b. Learning disabilities	_____	_____
c. Disturbances in reality testing (psychosis)	_____	_____
d. Degree of Affective/behavioral disturbance manifested	_____	_____
e. Nature of personality structure	_____	_____

5. Describe your treatment plan and how it is going to be affected by the results of the testing.



Member Name: _____ DOB: _____

6. Will the testing be used to corroborate present plans for treatment?

7. Designate who will perform psychological testing if not self:

Name: _____ Phone: _____ Lic#: _____
(Only independently licensed psychologists are authorized to perform psychological testing.)

I hereby certify that I am the patient's therapist and the above statements are true and correct:

Name of Provider Phone

Address Signature of Provider/Date

City/State/Zip

(FOR OFFICE USE ONLY)

This request for psychological testing has been:

_____ APPROVED: Total Hours: _____

The tests approved above are the only tests which are being authorized. After the initial test results are evaluated, further testing may be indicated. If so, the provider should resubmit an update pre-certification form with a copy of previous test results attached.

_____ NOT CERTIFIED

The Medical Director reviews all requests, which are questioned by the Reviewer and must concur prior to denial.

Medical Director Signature Date