

Instructions

In order to facilitate rapid processing of your request, please:

- Type or print legibly to prevent the return of forms for clarification.
- Wait for authorization; it must be obtained PRIOR to actual testing. This service must be pre-certified.
- Identify self-report inventories, checklists, etc. (to be completed by the member, parent or clinician).
- Note that evaluations for the specific and/or primary purpose of diagnosing learning disabilities or intellectual functioning cannot be authorized. These evaluations should be pursued through the school system.
- **Fax the completed form to 866.368.4562.**

Member Information

Last name, first name, MI _____ Birthdate _____

Social Security # _____ Select Health ID# _____ Request date _____

Provider Information

Agency requesting service _____ Date of testing *(if scheduled)* _____

Contact person _____ Fax # _____ Call back # _____

Agency address, city & state _____

Clinical Information

Referral Source _____

Clinical symptoms & reason(s) for referral for testing:

Specific question(s) that testing is intended to answer and why it/they cannot be answered through another means:

Clinical Information continued

Description of how the psychological/neuropsychological testing will direct treatment planning. Include justification as to why other interventions (e.g. psychiatric evaluation, outpatient therapy, second opinion, etc.) would not better accomplish the same results.

Treatment History, including service (e.g. outpatient, inpatient, BHRS), provider and dates:

Working diagnosis and rule-outs:

For neuropsychological testing requests, describe any neurological incidents/events and/or neurodevelopmental concerns.

Other information:

