Select Health of South Carolina

Healthy Connections

Psychological/Neuropsychological Testing Request

SUBMIT TO: Behavioral Health Utilization Management Fax: **888-796-5521**.
For assistance please call **866-341-8765**.

Treatment requests must be documented in whole hours and assessments must justify the clinical need for all tests requested.

Testing will not be authorized under any of the following conditions:

1. The referral question can be answered through a comprehensive diagnostic interview and/or routine screening or assessment measure (e.g. self-report inventories, rating scales).
2. Testing is not directly relevant or necessary for proper diagnosis and/or development of a treatment plan for a behavioral health disorder or associated medical condition.
3. Testing is primarily for educational, vocational or legal purposes.
4. Testing is routine for entrance into a treatment program.
5. The tests requested are experimental or have no documented validity.
6. The time requested to administer the testing exceeds established time parameters.

Demographic information

Patient name:	DOB:	Age:
Referral source:	Medicaid ID/SS #/Patient ID:	

Provider information

Provider name:		Agency name:
Professional credential: ☐ MD ☐ PhD ☐ Other:		Address:
Phone:	Fax:	Medicaid/NPI/Tax ID:

Date of diagnostic interview/intake: Please attach a summary of the diagnostic interview, including scores from screening tools used.	
Behavioral and medical diagnoses:	
Specific referral reason/question:	
State how the anticipated results of the testing will affect the patient's treatment plan:	
Was a substance abuse assessment completed? ☐ Yes ☐ No	Results (or attach the results to this request):
Has previous psychological or neuropsychological testing been conducted? ☐ Yes ☐ No	
If yes, please give details to include tests that have been conducted, when they were completed, and reason for testing:	

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Medications			
Medication name	Dose/frequency	Start date	Prescribing provider

Testing request			
Start date	Stop date	CPT code	Units requested

Please indicate the tests planned to answer the clinical questions			
☐ WISC (120 min.)	☐ MMPI-A (60 min.)	☐ ADOS (120 min.)	☐ BRIEF (60 min.)
☐ WAIS (120 min.)	☐ MACI (60 min.)	☐ Conner's Continuous Performance (60 min.)	☐ Conner's Continuous Performance – Kiddie (30 min.)
☐ WPPSI (120 min.)	☐ NEPSY (60 min.)	☐ Vineland (60 min.)	☐ MAPI (60 min.)
☐ MMPI (60 min.)	☐ PAI (60 min.)	☐ DAS (60 min.)	
☐ BASC/CBCL (30 min. each): ☐ Self ☐ Parent ☐ Teacher ☐ Other	☐ Autism Checklist (15 min. each): ☐ Self ☐ Parent ☐ Teacher ☐ Other	☐ ADHD Checklist (15 min. each): ☐ Self ☐ Parent ☐ Teacher ☐ Other	☐ Other:
☐ Other:	☐ Other:	☐ Other:	☐ Other:
If you are requesting more time for a test than is the standard allowed time, please indicate the reason:			
Additional comments:			

Provider Signature: _____ Date: _____