

**Request for authorization—psychological testing**

Submit via fax to **1-800-505-1193** or via web portal at **www.Anthem.com/KYMedicaidoc**.

**General information**

Member name:		Date of birth:		Member ID:	
Psychologist name:	Provider ID:	Phone:	Email:		
		Fax:			

Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders, nor is psychological testing indicated for the administration of brief behavior rating scales and inventories. Such scales and inventories are an expected part of a routine and complete diagnostic process. Other than in exceptional cases, a diagnostic interview and relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization. Requests for placement purposes and forensic purposes are not covered benefits. Requests for educational testing or learning disabilities assessment for educational purposes should be referred to the public school system.

**Clinical assessment**

Indicate which of the following assessments have been completed.

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

**Clinical information**

Indicate which of the following problems and symptoms presented a need for testing.

<input type="checkbox"/> Inattention	<input type="checkbox"/> Irritability	<input type="checkbox"/> Disorganization	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Labile mood	<input type="checkbox"/> Lethargy	<input type="checkbox"/> Low motivation	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Poor attention span	<input type="checkbox"/> Acting out behavior	<input type="checkbox"/> Attention seeking	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions
<input type="checkbox"/> Low frustration tolerance	<input type="checkbox"/> Suicidal/homicidal ideation	<input type="checkbox"/> Violence/physical aggression	<input type="checkbox"/> Speech and language delays	<input type="checkbox"/> Other developmental delays
<input type="checkbox"/> Other:				
Duration of symptoms: <input type="checkbox"/> 0-3 Mo. <input type="checkbox"/> 3-6 Mo. <input type="checkbox"/> 6-9 Mo. <input type="checkbox"/> 9-12 Mo. <input type="checkbox"/> >12 Mo.				

**www.Anthem.com/KYMedicaidoc**

**Treatment history**

Please provide information regarding treatment history.

	Frequency	Duration of treatment	Is member still in treatment?	Have symptoms improved?
Individual therapy:				
Medication management:				
School-/home-based Tx:				
Other services:				

**Date of diagnostic interview:** \_\_\_\_\_

**Rating scales**

Please indicate which rating scales have been administered as part of your clinical assessment.

<input type="checkbox"/> BASC	<input type="checkbox"/> TSCC	<input type="checkbox"/> CDI	<input type="checkbox"/> STAI	<input type="checkbox"/> BDI
<input type="checkbox"/> Conner's	<input type="checkbox"/> Achenbach	<input type="checkbox"/> Brief	<input type="checkbox"/> MDQ	<input type="checkbox"/> BAI
<input type="checkbox"/> RAD	<input type="checkbox"/> CBCL	<input type="checkbox"/> MASC	<input type="checkbox"/> ADHD rating	<input type="checkbox"/> PCL-5
<input type="checkbox"/> Other:				
Please include any pertinent results of rating scales.				

**Other pertinent information**

Please include any other information that supports the request for psychological testing.

**Previous psychological testing**

Please include any information regarding previous psychological testing (e.g., dates of testing, results) and why retesting is requested.

**DSM-5/ICD-10 diagnoses**

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**Rationale for testing**

Please describe the rationale for testing. What are the current questions to be answered that cannot be addressed by the clinical interview, review of records and rating scales that you have already administered? How will the results of testing impact the course of treatment?

**Is this a request for a trauma assessment?**    Yes    No

**Psychological tests requested**

Please list the tests you are requesting and the administration time.

Total time requested in hours:

Provider signature: \_\_\_\_\_

Date: \_\_\_\_\_