OUTPATIENT BEHAVIORAL HEALTH
Prior Authorization Fax Form **Psychological Testing**

Complete and Fax to:
1-844-208-9113

This is a standard authorization request that may take up to 7 calendar days to process. **If this is an expedited request for MMA, HK, CW or Medicare, please contact us at 1-844-477-8313. For an expedited request for Ambetter members, please call 1-877-687-1169.**

☐ Request for additional units. Existing Authorization ☐☐☐☐☐☐☐☐☐☐☐☐ Units ☐☐☐☐

**** INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Date of Birth * (MMDDYYYY)

Member ID/Medicaid ID *

Last Name, First

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

☐ ***Same as Requesting Provider***

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code * (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

Number of sessions requested

Number of sessions completed

Member Assessment

Is member a danger to self or others? Yes No

If yes, describe:

Is Mental Status Exam (MSE) within normal limits? Yes No

If no, describe:

Other treatment patient is currently receiving

Anxiety | Depression | Withdrawn/poor social interaction | Mood instability | Psychosis/hallucinations | Bizarre behavior | Unprovoked agitation/aggression

Self-injurious behavior | Eating disorder sysmptoms | Poor academic performance | Behavior problems at home | Behavior problems at school

Inattention | Hyperactivity | Other

What question is to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing affect the care and treatment in a meaningful way?

Does the member have any significant medical illness, history of developmental problems, head injuries or seizures in the past? Yes No

Comments:

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 8 25 2016
FL-PAF-0675

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***** ***INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First

Date of Birth *
(MMDDYYYY)

Does the member have a family history of psychiatric disorders, behavior problems, or substance abuse?

Comments:

Is there any known or suspected history of physical or sexual abuse or neglect?

Comments:

Is the member's presentation on intake consistent with ADHD?

Yes **No**

Indicate the results of Conner's or similar ADHD rating scales, if given:

If member is a child, indicate the collateral information you have obtained from the school regarding cognitive/ academic functioning (i.e. teacher feedback, results of school standardized testing):

Date of diagnostic interview:
(MMDDYYYY)

Has member had a psychiatric evaluation?

Yes **No**

If yes, date of psychiatric evaluation:
(MMDDYYYY)

If yes, what was the basic focus and results?

Has member had previous psychological testing?

Yes **No**

If yes, date of psychological testing:
(MMDDYYYY)

Current Psychotropic Medications

Prescriber

Medication

Start date:
(MMDDYYYY)

Compliant(Y/N):

Yes **No**

Planned test

Test date:
(MMDDYYYY)

Units requested

Requested Authorization

Psych testing:
96101 96102 96103

NeuroPsych testing:
96116 96118 96119 96120

Aphasia assessment:
96105

Developmental testing:
96110 96111 96125

Doctor signature and date

(MMDDYYYY)

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