



SUBMIT TO:
NAME OF DEPARTMENT
ADDRESS
CITY, ST ZIP CODE
FAX:

INDIANA PSYCHOLOGICAL TESTING REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

<p><u>Member Information</u></p> <p>Patient Name: _____</p> <p>Health Plan: _____</p> <p>DOB: _____</p> <p>SS#: _____</p> <p>Patient ID#: _____</p> <p>Referral Source: _____</p>	<p><u>Provider Information</u></p> <p>(Please indicate by checking below, whether requested services should be authorized to the provider or agency.)</p> <p><input type="checkbox"/> Provider</p> <p><input type="checkbox"/> Group/ Agency Name: _____</p> <p>Professional Credential: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> Other: _____</p> <p>Physical Address: _____</p> <p>PHONE: _____ FAX: _____</p> <p>Medicaid/TPI/NPI#: _____ Tax ID#: _____</p>
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Referral Reason/Question: _____

- Testing will not be authorized under any of the following conditions:
1. Testing is primarily for educational or vocational purposes.
 2. Testing is primarily for legal purposes.
 3. Testing is primarily for cognitive rehabilitation.
 4. The tests requested are experimental or have no documented validity.
 5. The time requested to administer the testing exceeds established time parameters.
 6. Testing is routine for entrance into a treatment program.

Is this testing required for educational purposes, behavioral health purposes, or both?

Explain: _____

State how the anticipated results of the testing will effect the patient's treatment plan: _____

<p><u>DSM IV Axis</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">AXIS I</td> <td style="width: 33%;">R/O</td> <td style="width: 33%;">R/O</td> </tr> <tr> <td>AXIS II</td> <td colspan="2">_____</td> </tr> <tr> <td>AXIS III</td> <td colspan="2">_____</td> </tr> <tr> <td>AXIS IV</td> <td colspan="2">_____</td> </tr> <tr> <td>AXIS V</td> <td style="text-align: center;">CURRENT</td> <td style="text-align: center;">PAST YEAR</td> </tr> </table> <p>Danger to Self or Others? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain: _____</p> <p>MSE Within Normal Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain: _____</p> <p>List Current Medications:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Name/Strength</th> <th style="width: 40%;">Directions</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </tbody> </table>	AXIS I	R/O	R/O	AXIS II	_____		AXIS III	_____		AXIS IV	_____		AXIS V	CURRENT	PAST YEAR	Name/Strength	Directions	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	<p>What are the Current Symptoms Prompting the Request for Testing?</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Mood Instability</p> <p><input type="checkbox"/> Inattention</p> <p><input type="checkbox"/> Hyperactivity</p> <p><input type="checkbox"/> Withdraw/Poor Social Interaction</p> <p><input type="checkbox"/> Psychosis/Hallucinations</p> <p><input type="checkbox"/> Bizarre Behavior</p> <p><input type="checkbox"/> Unprovoked Agitation/Aggression</p> <p><input type="checkbox"/> Self-Injurious Behavior</p> <p><input type="checkbox"/> Eating Disorder Symptoms</p> <p><input type="checkbox"/> Poor Academic Performance</p> <p><input type="checkbox"/> Behavior Problems affecting life functions (e.g., school, home)</p> <p><input type="checkbox"/> Other, List _____</p> <hr/> <p>Comment/Explain:</p> <p>_____</p>
AXIS I	R/O	R/O																										
AXIS II	_____																											
AXIS III	_____																											
AXIS IV	_____																											
AXIS V	CURRENT	PAST YEAR																										
Name/Strength	Directions																											
_____	_____																											
_____	_____																											
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_____	_____																											

Was a Behavioral Health Evaluation completed (e.g., 90801)?

Yes No Date: _____

Results:

Was Previous Psychological Testing Conducted?

Yes No Date: _____

Basic Focus and Results:

HISTORY

When was the patient's last physical examination?

If ADHD is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available:

Positive Negative Inconclusive Not Applicable

Comment/Explain:

Start Date MM/DD/YY	Stop Date MM/DD/YY	CPT Code	Modifier(s)	Units Requested	Hours Requested

Please list the tests planned to answer the clinical questions:

Test	Reason for Use	Educational Yes/No	Number of Hours Requested for Test	Number of Hours Approved for Test

Indicate the total number of units and hours requested: _____

Provider Signature: _____

Date: _____