PLEASE TYPE ALL INFORMATION. NOTE THAT REQUEST WILL NOT BE ACCEPTED UNLESS COMPLETED IN DETAIL WITH ALL SUPPORTING INFORMATION ATTACHED.

Type of Service Requested: ☐ **Psychological Testing** ☐ **Neuropsychological testing** ☐ **Psychosexual testing**
See bottom of last page for potentially authorized CPT codes and units

Member Name: **DOB**

AHCCCS #:

Guardian: ☐**Yes** ☐**No** **Who:** ☐**Parent**: ☐ Other ☐**DCS**:

Other members of Team: ☐JPO ☐DDD ☐DCS☐Other

Treating Doctor/NP Name : **Phone/ email**:
Clinic: **Phone/ Email:**
Case Manager: **Phone/ Email:**
Requesting clinician/ title: **Phone and email**:
Current location of member: (*i.e. inpatient, foster care, family, home*)

What clinical question will be answered by testing?
(The evaluation is necessary to assess the extent of dysfunction and determine an effective behavioral health treatment plan and outcome goals or the evaluation is necessary to effect an expected change in the current behavioral health treatment plan and outcome goals)

Why can't this question be answered by a diagnostic interview, a medical and/or neurologic consult, review of psychological/psychiatric records, or second opinion?

Is this meant to support custody evaluations, parenting assessments, or court ordered testing? ☐**Yes** ☐**No**

What are the current symptoms and/or functional impairments related to testing question?

How would the results of testing affect the treatment plan (Address how this evaluation could benefit or improve the overall treatment approach for the member. Please provide the specific areas of concern for evaluation that could improve the proposed course of treatment or treatment planning.
please be specific)?

What are the diagnoses both behavioral health and medical ? (Please list all Diagnosis, *including substance use/abuse/dependence: Please be detailed including developmental disability if applicable.)*

Medical/Psychological/Neuropsychological Evaluation and Treatment:

Has patient had a psychiatric diagnostic evaluation? ☐Yes ☐No Date:
Please provide the psychiatric eval

Has patient had previous psychological /neuropsychologicaltesting? ☐Yes ☐No Date:
Please provide the report(s) of that testing
Focus of prior evaluation:

Has patient had previous psychosexual evaluation? ☐Yes ☐ No Date:
Please provide the report of that testing
If requesting psycho sexual testing what is the current legal status:
(adjudicated, or pending adjudication) Date:
Has there been treatment or evaluation of sexually maladaptive behavior with an outpatient provider? Please provide name, phone number, and records:

Please provide all Results of any consultations from specialists in neurology or psychiatry/behavioral health, if available.

The most recent complete history and physical examination and pertinent findings, including laboratory tests and diagnostic procedures that may be relevant to the evaluation request.

If current request is ADHD related, indicate latest results of Conners' or similar ADHD ratings scales: (please attach) ☐ **Positive** ☐ **Inconclusive** ☐ **Negative** ☐ **N/A** *(not ADHD related or no administration of rating scales)*

Is this testing intended to diagnose ADHD? ☐Yes ☐No

If yes, indicate prior attempts to diagnose including psychiatric evaluations, results of rating scales, school records, and any other assessment.

Is this testing intended to diagnose Autism Spectrum Disorders? ☐**Yes** ☐ **No**

If Yes: indicate prior attempts to diagnose including detailed Psychiatric Evaluation which should include a review of records of pediatrician, PCP, school observations, coordination of care, rating scales and any other supportsing doc.

Current Substance Use (please document all substance use within the last year and date of last use:

Has there been any neurological evaluation to assess or diagnosed a neurological condition (please be specific and provide dates and records)?

Please attach progress note from Neurologist and/ or note where collaboration occurred between neurologist and BHMP.

Request For Psychological/Neuropsychological Testing

Current Psychiatric ans medical Medication list with dosages and effect:

Name of medication	Dose	Target Symptoms	Effect/ duration of trial/ compliance

THE FOLLOWING MUST BE COMPLETED BY PSYCHIATRIC PROVIDER OR AGENCY MEDICAL DIRECTOR ,IF NOT ASSIGNED OR ASSIGNED PROVIDER IS NOT AVAILABLE.

Detailed Clinical summary from treating psychiatric provider for 6 months: .	
Clinical opinion and rationale (based on criteria) of psychiatric provider for testing request: .	
Printed Name of Provider:	**Email:**
Phone:	**Date:**
Signature of Provider	

Required Attachments:

- **Treating doctor /NP Evaluation and progress notes that detail assessment of clinical concern listed above.**
- **Any supporting rating scales**
- **Neurological assessment, reviewed by treating doctor /NP if for a Neuropsychological Evaluation**The most recent complete history and physical examination and pertinent findings, including laboratory tests and diagnostic procedures that may be relevant to the evaluation request
- Results of any consultations from sub-specialists in neurology or psychiatry/ behavioral health, if available.
- Results of any prior psychological /neuropsychological/psychosexual evaluation that may be available

Psychological testing: 96101- , 96102 -, 96103 -
Neuropsychological testing: 96116, 96118, 96119

Request For Psychological/Neuropsychological Testing

Psychosexual testing: 96101, 96102, 96103

Name of Identified Mercy Care RBHA Contracted Provider:

Servicing Provider/Facility Information
Servicing Provider Organization_____
Address_____ TIN#_____
NPI#_____ Phone#_____
Administrative Contact Name:_____
Billing Address: _____

Requesting Clinician: **Signature/Date:**
Supervisor Name: **Signature/Date:**

AMPM

CHAPTER 300 MEDICAL POLICY FOR AHCCCS COVERED SERVICES POLICY 320 SERVICES WITH SPECIAL CIRCUMSTANCES