SUBMIT TO
Utilization Management Department
Phone: 866-329-4701 Fax: 844-528-3453

illinicare health

OUTPATIENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

MEMBER INFORMATION

Name _____

Date of Birth _____

Member ID # _____

SSN # _____

Health Plan _____

PROVIDER INFORMATION

Provider Name _____

Group Name _____

Provider Tax ID# _____ NPI/#_____

Phone _____ Fax_____

Referal Source _____

PROVISIONAL DSM-IV DIAGNOSIS

The provider must report all diagnoses being considered for this patient.

Primary _____ R/O _____ R/O _____

Secondary_____

Tertiary_____

Additional_____

Additional_____

Danger to Self or Others (If yes, please explain)? ☐ Yes ☐ No_____

_____

MSE Within Normal Limits (If no, please explain)? ☐ Yes ☐ No _____

_____

WHAT ARE THE CURRENT SYMPTOMS PROMPTING THE REQUEST FOR TESTING?

☐ Anxiety
☐ Depression
☐ Withdrawn/poor social interaction
☐ Mood instability
☐ Psychosis/Hallucinations
☐ Bizarre Behavior
☐ Unprovoked agitation/aggression
☐ Self-injurious Behavior
☐ Poor academic performance
☐ Behavior problems at home
☐ Behavior problems at school
☐ Inattention
☐ Hyperactivity
☐ Eating disorder symptoms: _____
☐ Other _____
_____
_____

What is the question 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?

HISTORY

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past?

☐ Yes ☐ No Comments: _____

Does the patient have a family history of psychiatric disorders, behavior problems or substance use?

☐ Yes ☐ No ☐ Uncertain Comments: _____

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

☐ Yes ☐ No ☐ Uncertain Comments: _____

If ADHD is a diagnostic rule out, please complete the following: Is the patient's presentation on intake consistent with ADHD?

☐ Yes ☐ No

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

☐ Positive ☐ Negative ☐ Inconclusive ☐ N/A

Date of Diagnostic Interview _____

Has the patient had a Psychiatric Evaluation? ☐ Yes ☐ No If yes, date? _____

Basic Focus and Results_____

_____

Current Psychotropic Medications: _____

_____

PLEASE LIST THE TESTS PLANNED TO ANSWER THE CLINICAL QUESTION(S)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

PLEASE INDICATE THE NUMBER OF UNITS REQUESTED TO COMPLETE TESTS (1 UNIT = 1 HOUR INCREMENT):

_____

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

STANDARD REVIEW:
Standard 14-day time frame will be applied.

_____
Clinician Signature Date

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

_____
Clinician Signature Date

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