FROM | sunflower health plan

SUBMIT TO:
Utilization Management Department
Phone 1-844-518-9505 Fax: 1-844-824-7705

PSYCHOLOGICAL OR NEUROPSYCH TESTING AUTHORIZATION REQUEST FORM

***All Fields Must Be Completed For This Request To Be Reviewed. Please type or print neatly.**

Please indicate which level of care the member is currently engaged: ❑ INPATIENT ❑ OUTPATIENT

IDENTIFYING INFORMATION

Member Name ______________________ DOB ______________________ SSN ______________

Member ID # ______________________ Health Plan Name ______________________

Provider Name ______________________ OR Agency/Group Name ______________

Professional Credentials ______________________

Provider Phone # ______________________ Fax # ______________________

Address (street/city/state) ______________________

NPI # ______________________ Tax ID # ______________

Referral Source ______________________

DIAGNOSIS (PLEASE REPORT ALL DIAGNOSES BEING CONSIDERED FOR THIS MEMBER)

Primary (Required) ______________________ 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	❑ Psychosis/Hallucinations	❑ Eating disorder symptoms	❑ Inattention
❑ Depression	❑ Inexplicable Behavior	❑ Poor academic performance	❑ Hyperactivity
❑ Withdrawn/poor social interaction	❑ Unprovoked agitation/agression	❑ Behavior problems at home	❑ Other
❑ Mood instability	❑ Self-injurious Behavior	❑ Behavior problems at school	______________

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?

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MEMBER HISTORY

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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 ADHS rating scales, if given: ❑ Positive ❑ Negative ❑ Inconclusive ❑ N/A

If the patient is a child, please 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 ______________________________

Has the patient had a Psychiatric Evaluation? ❑ Yes ❑ No If yes, date of the interview ______________________________

Previous Psychological Testing? ❑ Yes ❑ No If yes, date? ______________________________

Basic Focus and Results ______________________________

CURRENT PSYCHOTROPIC MEDICATIONS

Prescriber: ❑ Psychiatrist ❑ General Practitioner ❑ Other

Medication Name	Date Started	Compliant? (Y/N)

REQUEST FOR AUTHORIZATION

Please check only one code:

Psych Testing:
❑ 96101 ❑ 96102 ❑ 96103

NeuroPsych Testing:
❑ 96116 ❑ 96118 ❑ 96119 ❑ 96120

Aphasia Assessment: ❑ 96105

Developmental Testing:
❑ 96110 ❑ 96111 ❑ 96125

Please list the tests planned to answer the clinical questions.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Number of units requested to complete tests: ______________________________

Provider Name ______________________________

Provider Signature ______________________________ Date ______________________________

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

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AMB 18-CE-KS-825492