Amerigroup
District of Columbia

https://providers.amerigroup.com/DC

Request for Authorization — Psychological Testing

Please submit this form electronically using our preferred method by logging onto Availity from the Amerigroup District of Columbia, Inc. provider website at https://providers.amerigroup.com/DC. This form can also be submitted via fax to 1-800-454-1193 on the last authorized day.

Note: We are unable to process illegible or incomplete requests.

General information

Patient name:		
DOB:	Age:	Patient ID:
Name of psychologist:	Address:	
Provider #:	Provider NPI:	
Provider phone #:	Provider fax #:	
Provider email:		

Formal psychological testing is neither clinically indicated for routine screening or assessment of behavioral health disorders nor indicated for the administration of brief behavior rating scales and inventories. Such scales and inventories are an expected part of a routine and complete diagnostic process. Other than in exceptional cases, a diagnostic interview and relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization. Requests for placement purposes, disability evaluations and forensic purposes are not covered benefits. Requests for educational testing or educational assessment for learning disabilities should be referred to the public school system. **This form is for psychological testing requests only. Requests for neuropsychological or autism testing need to be completed on their requisite forms.**

Clinical assessment: Indicate which of the following assessments were completed.

☐ Psychiatric and medical history	☐ Clinical interview with patient	☐ Structured developmental and social history	☐ Medical evaluation	☐ Consultation with school or other important persons	☐ Direct observation of parent-child interactions
☐ Interview with family members	☐ Consultation with patient's physician	☐ Brief inventories or rating scales	☐ Review of medical records	☐Review of academic records or IEP	☐ Family history pertinent to testing request

Please include any relevant clinical or medical records to support the testing request.

Clinical information: Indicate the presenting problems, symptoms and need for testing.

☐ Inattention	☐ Irritability	☐ Disorganization	☐ Depression	☐ Anxiety
☐ Labile mood	☐ Lethargy	☐ Low motivation	☐ Distractibility	☐ Impulsivity
☐ Poor attention span	☐ Acting out behavior	☐ Attention seeking	☐ Hallucinations	☐ Delusions
☐ Low frustration tolerance	☐ Suicidal or homicidal ideation	☐ Violence or physical aggression	☐ Speech and language delays	☐ Other developmental delays
☐ Other:				
Duration of symptoms: ☐ 0-3 months (MO) ☐ 3-6 MO ☐ 6-9 MO ☐ 9-12 MO ☐ > 12 MO				

Date of diagnostic interview: _____

Rating scales: Please indicate which rating scales have been administered as part of your clinical assessment (**prior to submitting the testing request**).

☐ BASC	☐ TSCC	☐ CDI	☐ STAI	☐ BDI
☐ Conner's	☐ Achenbach	☐ Brief	☐ MDQ	☐ BAI
☐ RAD	☐ CBCL	☐ MASC	☐ ADHD rating	☐ PCL-5
☐ Other:				

Treatment history: Please provide information regarding treatment history.

	How often does the enrollee receive services (weekly, biweekly or monthly)?	How long has the enrollee been in treatment?	Is the enrollee still in treatment?	Have the enrollee's symptoms improved?
Individual therapy				
Medication management				
School or home-based therapy				
Other services				

Other pertinent information

Please include any other information that supports the request for psychological testing:

Previous psychological testing

Please include any information regarding previous psychological testing (e.g., dates of testing or results) and why retesting is requested:

DSM-5 or ICD-10-CM diagnosis

Rationale for testing

Please describe the rationale for testing. What are the current questions to be answered that cannot be addressed by the clinical interview or review of records and rating scales that you have already administered? How will the results of testing impact the course of treatment?

Is this a request for a trauma assessment? ☐ **Yes** ☐ **No**

Psychological tests requested

Please list the tests you are requesting and the administration time. For tests with multiple versions, specify which one. If you are administering selected subtests, please indicate which ones. Please attach a separate sheet if necessary.

Please provide the hours and billing codes requested for the current psychological assessment:

96101 ____ hours (HRS) **96102** ____ HRS **96103** ____ HRS **Other**: ____
Total time requested in HRS: _____

Provider signature:	**Phone number:**

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.