PSYCHOLOGICAL TESTING PRE-AUTHORIZATION REQUEST FORM

All psychological testing requests must be pre-authorized using this form. Testing should not be administered until the requested authorization is approved. All sections of the form must be completed in order to process the testing request. Requests for testing should be made only after an initial assessment has been conducted. The initial assessment typically includes clinical interviews, relevant history, a review of prior evaluations and testing, coordination/consultation with current/previous providers, and coordination/consultation with the member's school personnel (if applicable). Please note that psychological testing requests for purposes of educational and/or legal reasons is not a covered benefit.

1. **Member information:**
   Member's name: _____ Member's CIN: _____
   Member's DOB: _____

2. **Person/agency requesting you to administer psychological testing (specify name):**
   ☐ Psychiatrist: _____ ☐ Court: _____
   ☐ Psychotherapist: _____ ☐ School staff (specify): _____
   ☐ CalOptima: _____ ☐ PCP/medical specialist: _____
   ☐ Member/parent: _____ ☐ Other: _____

3. **Testing provider information:**
   Provider Name: _____ Phone: _____
   Provider Licensure/Discipline: _____ Fax: _____
   Name of Agency/Org: _____ Email: _____

4. **DSM-5 diagnosis:**
   Date initial assessment completed:
   Code: _____ Description: _____ ☐ Current ☐ Provisional
   Code: _____ Description: _____ ☐ Current ☐ Provisional
   Code: _____ Description: _____ ☐ Current ☐ Provisional

5. **What is the clinical question(s) that psychological testing will answer? (Please be specific)**

6. **Can the question (#5) be answered through other means (a diagnostic interview, a medical and/or neurological consult, review of psychological/psychiatric records, or second opinion)?** ☐ Yes ☐ No. Please explain:

7. **What are the current symptoms and/or impairments?**

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8. How will the results of psychological testing be used for the treatment plan? (Please be specific)

9. To whom will the testing results be sent? _____

10. Mental health treatment:

A. Has the member been evaluated by a psychiatrist? ☐ Yes ☐ No If yes, date of eval. _____
B. Has the member been evaluated by a psychotherapist? ☐ Yes ☐ No If yes, date of eval. _____
C. Has the member had previous psychological testing? ☐ Yes ☐ No If yes, date of test _____
D. If yes to A, B, or C, have you coordinated with provider? ☐ Yes ☐ No

Please indicate the results of the coordination:

11. Is the member engaged in active substance use, in withdrawal, or in recovery from chronic use? ☐ Yes ☐ No

12. Were rating scales administered for ADHD? ☐ Yes ☐ No

A. If Yes, results of the rating scale(s): ☐ Positive ☐ Inconclusive ☐ Negative
B. Scales administered: _____
C. If member is a child and ADHD is a diagnostic rule out, indicate the information obtained from and coordination with the school regarding cognitive/academic functioning (i.e., standardized testing results):

13. Psychological tests requested:

Name of Test:	Test Domain (i.e. personality, cognitive, etc.):	Time Requested (per test):
	Total Number of Hours Requested:	

14. Provider completing request form:

Print name of provider: _____

Signature of provider: _____ Date: _____