Healthy Blue

Dual Advantage

Provider Bulletin
October 2020

Request for Authorization: Psychological Testing

Please submit this form electronically using our preferred method at **https://www.availity.com***. This can also be submitted via fax to **1-844-430-1703.**

General information

Member information					
Member		DOB		Member ID	
Provider information					
Psychologist name				Provider ID	
Phone		Fax		Email	

Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders, or 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 all relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization. Requests for placement and forensic purposes are not covered benefits. Requests for educational testing and assessment of learning disabilities for educational purposes should be referred to the public school system.

Clinical assessment

Indicate which of the following assessments have been completed.

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

Clinical information

Indicate which of the following problems and symptoms present a need for testing.

☐Inattention	☐Irritability	☐Disorganization	☐Depression	☐Anxiety
☐Labile mood	☐Lethargy	☐Low motivation	☐Distractibility	☐Impulsivity

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

☐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 mo. ☐ 3-6 mo. ☐ 6-9 mo. ☐ 9-12 mo. ☐ >12 mo.				

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Treatment history
Please provide information regarding treatment history.

	Frequency	Duration of treatment	Is member still in treatment?	Have symptoms improved?
Individual therapy				
Medication management				
School-/home-based				
Other services				

Date of diagnostic interview:
_____

Rating scales: Please indicate which rating scales have been administered as part of your clinical assessment.

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

☐ Other:
Please include any pertinent results of rating scales.

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 (such as dates of testing or results) and why retesting is requested.

DSM-5/ICD-10 diagnoses

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, 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.
Total time requested

Provider signature: _____Date:_____

Protected Health Information (PHI)
These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at **1-800-499-9554**.

Providers: You are required to return, destroy or further protect any PHI you receive pertaining to patients that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

☐ By checking this box, I hereby certify that the protected health information (PHI) contained in the correspondence received in error has been destroyed and has not otherwise been retained, utilized, or further disclosed. In the event the PHI must be retained it will further be protected until the time it can be destroyed.