AmeriHealth Caritas Delaware

Psychological/Neuropsychological Testing Request

Fax this request to Behavioral Health Utilization Management at **1-877-234-4273**. For assistance, please call **1-855-301-5512**.

AmeriHealth Caritas Delaware requires a prior authorization and a medical necessity review for psychological or neuropsychological testing. This form can be submitted for that prior authorization.

Testing requests should include additional clinical documents and assessments to justify the clinical need for all requested tests.

Testing will not be authorized under any of the following conditions:

- The referral question can be answered through a comprehensive diagnostic interview and/or routine screening or assessment measure (e.g., self-report inventories or rating scales).
- Testing is not directly relevant or necessary for proper diagnosis and/or the development of a treatment plan for a behavioral health disorder or associated medical condition.
- Testing is primarily for educational, vocational, or legal purposes.
- Testing is routine for entrance into a treatment program.
- The requested tests are experimental or have no documented validity.
- The requested time to administer the testing exceeds established time parameters.

Demographic information		
Member name:		
Date of birth (mm/dd/yyyy):		Age:
Referral source:	Medicaid ID/Social Security number/patient ID:	

Provider information				
Provider name:				
Professional credential:	☐ M.D.	☐ Ph.D.	☐ Other:	
Agency name:				
Address:				
Phone:	Fax:	NPI:	Tax ID:	
Date of diagnostic interview/intake: (Please attach a summary of the diagnostic interview, including scores from screening tools used.)				
Behavioral and medical diagnoses:				
Specific referral reason or question:				

Provider information (continued)

State how the anticipated results of the testing will affect the patient's treatment plan:

Was a substance abuse assessment completed? ☐ Yes ☐ No

Results (or attach the results to this request):

Has previous psychological or neuropsychological testing been conducted? ☐ Yes ☐ No

If yes, please give details to include tests that have been administered, when they were completed, and the reason for testing:

Medications

Medication name:	Dose or frequency:	Start date:	Prescribing provider:

Testing request

Start date:	Stop date:	CPT code:	Units requested:

Please indicate the tests planned to answer the clinical questions.			
☐ WAIS (120 minutes)	☐ NAB 5	☐ ADOS (120 minutes)	☐ BRIEF (60 minutes)
☐ Vineland Adaptive Behavior Scales (VABS) (60 minutes)	☐ Brief Visuospatial Memory Test-Revised (BVMT-R)	☐ Conners' Continuous Performance (60 minutes)	☐ MMPI (60 minutes)
☐ Personality Assessment Inventory (PAI) (60 minutes)	☐ Autism checklist (15 minutes each): ☐ Self ☐ Parent ☐ Other	☐ ADHD checklist (15 minutes each): ☐ Self ☐ Parent ☐ Other	☐ M-FAST:
☐ Wisconsin Card Sorting Test (WCST)	☐ Other:	☐ Other:	☐ Other:
If you are requesting more time for a test than is the standard allowed time, please indicate the reason:			
Additional comments:			

Provider signature:	Date:

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