Psychological and Neuropsychological Testing Request Form

AmeriHealth Caritas Iowa

Incomplete or illegible forms will delay processing. Please fax to AmeriHealth Caritas Iowa Behavioral Health Utilization Management (BH UM) at **1-844-214-2469**. For assistance, please contact **1-844-214-2474**.

Prior authorization is not required for psychological or neuropsychological testing that is three hours or less.

Treatment requests must be documented in whole hours, and assessments must justify the clinical need for all tests requested.

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

1. Testing is primarily for educational or vocational purposes.
2. Testing is primarily for legal purposes.
3. The tests requested are experimental or have no documented validity.
4. The time requested to administer the testing exceeds established time parameters unless documented on this form. If additional hours are needed, please complete the section below.
5. Testing is routine for entrance into a treatment program.

Is this testing for admittance or renewal of a waiver service? ☐ Yes ☐ No
If yes, please complete the following.
Date of last assessment:
List of assessment tools used and results:

Demographic information		
Patient name:	Date of birth:	Age:
Referral source:		
Medicaid ID, Social Security number (SSN), or AmeriHealth Caritas Iowa member ID number:		

Provider information	
Provider name:	Agency name:
Professional credentials: ☐ M.D. ☐ Ph.D. ☐ Other:	
Address:	
Phone:	Fax:
Medicaid, National Provider Identifier (NPI) number, or tax ID:	

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Provider information
Referral reason or question:
Behavioral and medical diagnosis:
State how the anticipated results of the testing will affect the patient's treatment plan:
Was a behavioral health or substance use disorder assessment completed? ☐ Yes ☐ No Results or attach the request with this form:
Has previous psychological or neuropsychological testing been conducted? ☐ Yes ☐ No If yes, please give details to include tests that have been conducted, when they were completed, and reason for testing:

List all current medications

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Testing request			
Start date	Stop date	CPT code	Units requested

Please indicate the tests planned to answer the clinical questions			
☐ WISC-IV (120 min)	☐ MMPI-A (60 min)	☐ ADOS (60 min)	☐ BASC (30 min)
☐ WAIS (120 min)	☐ MACI (60 min)	☐ Conner's Continuous Performance (60 min)	☐ Autism checklist (15 min)
☐ WPPSI-R (120 min)	☐ NEPSY (60 min)	☐ Vineland (60 min)	☐ Sentence completion forms (15 min)
☐ MMPI (60 min)	☐ PAI (60 min)	☐ DAS (60 min)	☐ ADHD checklist (15 min)
☐ Other:	☐ Other:	☐ Other:	☐ Other:
☐ Other:	☐ Other:	☐ Other:	☐ Other:

If you are requesting more time for a test than is the standard allowed time, please indicate the reason:
Additional comments:

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review, or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Provider signature:_____ Date:_____