

# Psychological & Neuropsychological Testing Request Form



4417 Corporation Lane, Ste 250  
Virginia Beach, VA 23462

Optima Health Plans  
Psychological & Neuropsych Testing  
(757) 552-7174 (800) 648-8420  
Fax: (757) 552-7176 (888) 576-9675

Member Name: \_\_\_\_\_ Member Number: \_\_\_\_\_

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Provider \_\_\_\_\_ Phone: \_\_\_\_\_  
(name and licensure)

**Testing Provider** \_\_\_\_\_  
(name and licensure)

Provider # \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Form completed by: \_\_\_\_\_

- Inpatient     Outpatient
- CHOOSE ONLY ONE**
- PSYCH     NEUROPSYCH

1. Today's Date \_\_\_\_\_ Date of Psych Eval \_\_\_\_\_

2. Has any previous psychological testing been done within the last year? Yes  No

If yes, why is additional testing recommended?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Presenting Problem (if you need additional space feel free to attach a separate sheet): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Diagnosis: Current or Provisional

Code	Description
_____	_____
_____	_____
_____	_____
_____	_____

5. Related to this patient's mental health treatment, what is the referral question(s) that psychological testing will specifically address? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Member Name: \_\_\_\_\_

Member Number: \_\_\_\_\_

6. Related to this patient's mental health treatment, please check all of the following services that have already been provided:

- Initial Interview/Clinical Evaluation
- Psychiatric Evaluation
- Interview with Family/Parents
- Review of School Record (to include behavioral observations, teacher reports, school psychologist report)
- Review of previous treatment record/relevant history
- Consultation with PCP/other treating providers
- If others, who: \_\_\_\_\_
- CBCL or other behavioral rating scale completed
- Neurological Exam
- Neuro Imaging Techniques (CT,MRI, PET Scan, Spec CT)
- Other \_\_\_\_\_

7. Explain how the results from the above services are insufficient to answer the referral question.

\_\_\_\_\_

\_\_\_\_\_

8. How will the testing results impact treatment for this patient? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Please attach a test list or list recommended tests to answer the referral question(s).

Tests	Time	Total Time Requested  _____
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

SBHS regards psychological testing as a highly specialized component of the process of clinical assessment. Authorization determinations are based on the application of a nationally recognized set of medical necessity criteria, the Mihalik Medical Necessity Manual for Behavioral Health, member eligibility, covered services and benefit availability. The testing provider is responsible for providing the necessary information to obtain authorization for psychological testing. Incomplete forms will be returned to the testing provider.

**First Submission:** Date Rcv'd \_\_\_\_\_ Log In \_\_\_\_\_ Log Out \_\_\_\_\_ File \_\_\_\_\_

Date \_\_\_\_\_ Hrs Auth'd \_\_\_\_\_ Hrs Not Auth'd \_\_\_\_\_ Reason \_\_\_\_\_ Reviewer- \_\_\_\_\_

**Recon Request:** Date Rcv'd \_\_\_\_\_ Log In \_\_\_\_\_ Log Out \_\_\_\_\_ File \_\_\_\_\_

**Recon:** Date \_\_\_\_\_ Hrs Auth'd \_\_\_\_\_ Hrs Not Auth'd \_\_\_\_\_ Reason \_\_\_\_\_ Reviewer- \_\_\_\_\_