oklahoma complete health

Psychological/neurological testing authorization form

Submit completed form electronically through Availity or by fax as directed by your insurance provider.

Today's date: _____ **Provider's office contact:**_____

Phone: _____ **Secure fax:** _____

Provider/facility requesting services

Provider/agency group name and credentials:

_____

EIN/TIN: _____ **Provider NPI used for billing:** _____

Address: _____ **City, State, ZIP:** _____

Treating/servicing provider (if different)

Provider name and credentials: _____

EIN/TIN: _____ **Treating provider' NPI:** _____

Start date of service: _____ **End date of service:**_____

Member information

Last name: _____ **First name:** _____ **Date of birth:** _____

Parent/guardian name: _____

Member ID: _____ **Insurance/health plan name:** _____

Member phone: _____ **Authorization reference number:** _____

Referral Source: _____

Clinical interview date (90791): _____

Diagnostic information

Current ICD-10 diagnostic codes

Current diagnosis if any. Include ICD10 code and description:

_____

Previous diagnosis if any. Include ICD10 code and description:

_____

Diagnoses to be evaluated or ruled out with this testing. Include ICD10 code and description:

_____

Safety assessment

Danger to self or others? ☐ Yes ☐ No

If yes, please explain and action taken to secure the patient's safety:

_____

MSE within normal limits? ☐ Yes ☐ No

If no, please explain: _____

Current symptoms and clinical presentation

Current symptoms prompting the request for testing

☐ Anxiety
☐ Depression
☐ Withdrawn/poor social interaction
☐ Mood instability
☐ Psychosis/hallucinations
☐ Bizarre behavior
☐ Unprovoked agitation/aggression
☐ Self-injurious behavior
☐ Behavior problems at home
☐ Behavior problems at school
☐ Inattention
☐ Hyperactivity
☐ Poor academic performance
☐ Disordered eating
☐ Other:_____

Duration of symptoms:
☐ 0-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ Greater than 12 months

What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information?

_____

How will testing affect the care and treatment in a meaningful way?

_____

Clinical assessment completed

Check all assessment components completed:

- ☐ Clinical interview with patient
- ☐ Consultation with school officials/other important persons
- ☐ Direct observation of parent-child interactions
- ☐ Medical evaluation
- ☐ Review of academic records/IEP
- ☐ Structured developmental and social history
- ☐Other:_____
- ☐ Consultation with patient's provider
- ☐ Family history pertinent to testing
- ☐ Interview with family members
- ☐ Review of medical records
- ☐ Psychiatric and medical history

Rating scales administered

Brief inventories/rating scales: _____

Has a screener been administered? ☐ Yes ☐ No

If yes, please indicate which screener:

_____

Date of screening:

_____

Brief summary of results: _____

_____

_____

Member history

Medical history

Does the patient have any significant medical illnesses, developmental problems, head injuries or seizures? ☐ Yes ☐ No

Explain: _____

Medical diagnostic testing completed related to referral question (if applicable):

_____

_____

Developmental history

Did the patient have any developmental concerns? ☐ Yes ☐ No ☐ Uncertain

Comments (e.g. describe developmental milestones, any therapies such as PT/OT/Speech):

_____

_____

Family history

Does the patient have a family history of psychiatric disorders, behavior problems or substance use? ☐ Yes ☐ No ☐ Uncertain

Comments:_____

Trauma history

Is there any known or suspected history of physical or sexual abuse or neglect?
☐ Yes ☐ No ☐ Uncertain

Comments_____

Reported or DHS involvement: ☐ Yes ☐ No ☐ Uncertain

Date reported, if known:

_____

Substance use history ☐ Yes ☐ No ☐ Uncertain

If yes, please indicate substance and frequency:

_____

Date of last use:

_____

If yes, potential impact on testing and action(s) taken by provider:

_____

Comments (required):

_____

School/academic information

If the patient is a child, please indicate collateral information obtained from school regarding cognitive/academic functioning (teacher feedback, standardized testing results):

☐ Yes ☐ No ☐ Unknown

_____

_____

Additional historical information

(Examples: trauma in childhood, instability in home life, frequent moves, psychiatric hospitalization history, ongoing counseling, prior testing, foster care placement)

_____

_____

Treatment history

Service	Frequency	How long in treatment?	Still in treatment?	Symptoms improved?
Individual therapy			☐ Yes ☐ No	☐ Yes ☐ No
Medication management			☐ Yes ☐ No	☐ Yes ☐ No
School/home-based management			☐ Yes ☐ No	☐ Yes ☐ No
Other services			☐ Yes ☐ No	☐ Yes ☐ No

Previous psychological assessment/testing

Has the patient had a previous psychological assessment? ☐ Yes ☐ No ☐ Unknown

If yes, date(s): _____

Basic focus and results: _____

Current psychotropic medications

Medications:_____
Indicate if medications are effective for diagnosis identified? ☐ Yes ☐ No ☐ Unknown
Comments: _____
If patient is not currently on medications but were previously, please indicate: _____
_____

Code	Description	Units	Frequency
96130	Psychological testing evaluation services (first hour)		
96131	Psychological testing evaluation services (additional hours)		
96132	Neuropsychological testing evaluation services (first hour)		
96133	Neuropsychological testing evaluation services (additional hours)		
96136	Psychological/neuropsychological test administration/scoring by professional (first 30 min)		
96137	Psychological/neuropsychological test administration/scoring by professional (additional 30 min)		
96138	Psychological/neuropsychological test administration/scoring by technician (first 30 min)		
96139	Psychological/neuropsychological test administration/scoring by technician (additional 30 min)		
96112	Developmental test administration (first hour)		
96113	Developmental test administration (additional 30 min)		
96116	Neuro-behavioral status exam (first hour)		
96112	Neuro-behavioral status exam (additional hours)		
96146	Automated testing and result		

Requested testing

List proposed battery of tests:

_____

_____

_____

CPT codes/service codes requested

Number of units and hours requested total: _____

Additional information

Please attach any relevant medical records and/or clinical diagnostic assessment to support the request for testing.

_____

Other pertinent information:

_____

_____

Provider signature: _____ Date: _____

IMPORTANT NOTES:

- Formal psychological testing is neither clinically indicated for routine screening or assessment of behavioral health disorders nor for the administration of brief behavior rating scales and inventories.
- Other than in exceptional cases, a diagnostic interview and relevant rating scales should be completed prior to submission of requests for psychological testing authorization.
- Requests for placement and forensic purposes are not covered benefits.
- Requests for educational testing or learning disabilities assessment for educational purposes should be referred to the public school system.
- Neuro psych (96132 and 96133) and psych testing (96130 and 96131) cannot be requested in combination
- Base codes (96130 and 96132) should only be billed one time per episode of evaluation.