Psychological Testing Authorization Form

Submit completed form electronically using our preferred method at **Availity** or by fax to **1-833-974-0059**.

Today's date:	
Contact at provider's office:	Secure fax:
Name of requestor:	Phone:
Note: Please provide appropriate contact information, including best working phone number for Humana staff to contact you if we need clarification or additional information to complete the request.	

Member information		
Last name:	First name:	
Humana ID:	Medicaid ID:	Date of birth:
Parent/guardian name:		Phone:
Member's living arrangements: ☐ At home with guardian ☐ Group home ☐ Foster home		
Authorization reference number (if applicable):		

Requesting provider/facility		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Treating/servicing provider		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Diagnosis code(s) and dates of service (DOS)			
ICD-10*:	ICD-10*:	ICD-10*:	ICD-10*:
Start date of service:		End date of service:	

* ICD-10 codes are from the International Classification of Diseases, Tenth Edition.

Humana
Healthy Horizons®
in Louisiana

316907LA0923-F LAHLRW2EN0923

Service code(s)		
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:

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. **Such scales and inventories are an expected part of a routine and complete diagnostic assessment.** Other than in exceptional cases, a diagnostic interview and 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 or learning disabilities assessment for educational purposes should be referred to the public school system.

Clinical assessment

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

Clinical information: Which problems or symptoms present a need for testing?

- ☐ Acting-out behavior
- ☐ Anxiety
- ☐ Attention-seeking behavior
- ☐ Delusions
- ☐ Depression
- ☐ Disorganization
- ☐ Distractibility
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Inattention
- ☐ Irritability
- ☐ Labile mood
- ☐ Lethargy
- ☐ Low frustration tolerance
- ☐ Low motivation
- ☐ Other developmental delays
- ☐ Poor attention span
- ☐ Speech and language delays
- ☐ Suicidal or homicidal ideation
- ☐ Violence or physical aggression
- ☐ Other: _____

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

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

Treatment history				
Service	Frequency	How long has member been in treatment?	Is member still in treatment?	Have symptoms improved?
Individual therapy			☐ Yes ☐ No	☐ Yes ☐ No
Medication management			☐ Yes ☐ No	☐ Yes ☐ No
School- or home-based management			☐ Yes ☐ No	☐ Yes ☐ No
Other services			☐ Yes ☐ No	☐ Yes ☐ No
Date of diagnostic interview				

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

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

Please note pertinent results of rating scales:

Other pertinent information

Previous psychological testing: Please include assessments and dates.

Provider signature:	**Date:**