Behavioral Health Service Request Form

Psychological and Neuropsychological Testing
Please submit to the WellCare Advocate Complete FIDA (Medicare-Medicaid Plan) dedicated fax line: 1-855-550-8977

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan 14 days prior to the date the requested services will be performed.
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request ____________________ Date Signed ____________________

MEMBER INFORMATION

Last Name:		**First Name, Middle Initial:**		**Date of Birth:**	
Phone:		**Member ID:**		**Gender:**	☐ **Male** ☐ **Female**
Third Party Insurance:	☐ **Yes** ☐ **No**	If **yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.		**Languages Spoken:**	

TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name:		**First Name:**		**NPI Number:**	
Provider ID:		**Participating:**	☐ **Yes** ☐ **No**	**Discipline/Specialty:**	
Address:		**City and State:**		**ZIP:**	
Phone:		**Fax:**		**Office Contact:**	

FACILITY/AGENCY INFORMATION

Name:		**Facility ID:**		**NPI Number:**	
Address:		**City and State:**		**ZIP:**	
Phone:		**Fax:**		**Office Contact:**	

SERVICE TYPE REQUESTED	LIST CPT CODE(S) AND NUMBER OF EACH REQUESTED	LIST THE SPECIFIC TESTS/SCALES REQUIRED
Psychological Testing:		
Neuropsychological Testing:		
Requested Start Date:		

DSM-IV DIAGNOSIS (AXIS I–V)

Primary Diagnoses:		**R/O:**	
Secondary Diagnoses:		**R/O:**	
Medical Problems:			

Current GAF/CAFAS:		**Highest GAF/CAFAS in Past Year:**	
Current Total LOCUS/CALOCUS Score (if applicable):		**Current ASAM Dimension Scores (if applicable):**	

RATIONALE FOR REQUEST

Who initiated the testing request:

☐	**Court**	☐	**Psychiatrist**
☐	**DJJ**	☐	**Psychologist**
☐	**Parent**	☐	**School**
☐	**PCP**	☐	**State agency**

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What is the overall clinical question that needs to be answered by the requested testing?
Has the member had an evaluation by a psychiatrist? If so, by whom and when? If not, why not?
Has the member had a diagnostic interview? If so, by whom and when?
Has the member had testing before? If so, by whom and when?
If testing was previously done, please list the instruments and results:
Why can't the questions at hand be answered by a diagnostic interview, a review of the member's record or a second opinion instead of testing?
Is the testing associated with a DX or potential DX of ADHD? If so, indicate the latest Conner's or similar ADHD ratings scales:
Is substance use a factor? If so, describe:

CURRENT MEDICATIONS (PSYCHOTROPIC AND MEDICAL)			
Medication:	Dosage:	Frequency:	Adherent:
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Any medication contraindications? If yes, describe:			