



REQUEST FOR PSYCHOLOGICAL TESTING

Please submit your request prior to providing services, otherwise payment may be denied. Fax to: CONTACT Behavioral Health Services 1-480-756-6776, or Call: 1-800-888-1477

Date of Request: _____

Patient Name: _____ Date of Birth: _____ Member ID#: _____

Person/Agency Requesting the Psychological Testing

- Psychologist Court School
- Psychiatrist Parent PCP/Medical Specialist
- Psychotherapist Teacher Other: _____

Clinician to Complete Testing

Name/Degree: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

Patient Information

- Please attach a copy of the most recent psychiatric diagnostic assessment (90801) report.
- What are the questions to be answered by the psychological testing?

- What information is the psychological testing expected to provide that cannot be determined through other means, such as a comprehensive clinical assessment, a review of pertinent records, a medication review, use of observational rating scales, or second opinions?

- How will the results of the testing be used to guide treatment decisions?

- What testing is requested?

Total number of hours requested: _____

CPT code requested: 96100 96117

Complete names and types of tests:

Time requested for administration, scoring, interpretation and report preparation of each test:
