Psychological Testing
Pre-Service Authorization Form

Please submit this form with the Behavioral Health 50-1 Treatment Authorization Request Form
Behavioral Health Department Secure Link: https://gateway.cencalhealth.org/form/bh
Behavioral Health Fax: (805) 681-3070

If you have any questions, please contact our Behavioral Health Provider Line: (805) 562-1600

Member Information

Member Name: _____ CenCal Member ID: _____

Member Date of Birth (DOB): _____

Referring Provider (Who referred the member for consultation for psychological testing)

Name: _____

NPI: _____ Phone: _____

Servicing Provider

Name: _____

NPI: _____ Phone: _____

How was the information in this form obtained:

- ◯ Patient
- ◯ Patient's family or authorized representative
- ◯ Primary Care Physician (Required)
- ◯ Therapist
- ◯ Psychiatrist
- ◯ Other: _____

1. **What is the Patient's abnormality that requires quantification, monitoring of change, or differentiation of cause?**

2. **Is the patient able to participate (mental status, intellectual or cognitive abilities, language skills, or developmental level is appropriate to proposed testing)?**
   Is member currently under the influence of any substances?
   Please note that the member should not be engaged in active substance use, in withdrawal, or in recovery from recent chronic use.

3. **How is the testing necessary and the information achieved by psychological testing not attainable through routine medical, neurological or psychological assessment?**

4. **What is the specific clinical question (identification, quantification, or assessment) that is present that can be answered by testing in order to establish diagnosis or inform rehabilitation or treatment plan?**

5. **What evaluative methods have been used (psychiatric, medical, neurological) and failed to answer the clinical question?**
   Psychological testing is clinically indicated and medically necessary when medical, neurological, mental status, and psychiatric examinations have been done as indicated. Additionally, diagnostic testing has been done as indicated (e.g. CT scan, MRI).
   Please provide these notes as well in your request.

Last Medical exam

Provider Name:

Date:

Findings:

Last Mental Status exam

Provider Name:

Date:

Findings:

Last Psychiatric examination

Provider Name:

Date:

Findings:

Last Neurological exam

Provider Name:

Date:

Findings:

Diagnostic testing completed

Provider Name:

Date:

Findings:

Type:

Date:

Findings:

6. **Please describe how the proposed Psychological testing engages family, caregivers, and other people impacted by and in the position to affect patient behavioral as appropriate.**

7. **How will the Psychological testing addresses co-morbid medical, psychiatric, and/or substance use disorders?**

8. **Will the results of the proposed testing affect care or treatment of patient? In other words, will the testing contribute substantially to the decision of the need for a treatment plan/ rehabilitive or habilative needs, or modification to the treatment plan? Please explain.**

9. **Who will the results be shared with?**

Test Name (No abbreviations)	Test Domain	How will this answer the support the purpose of testing?	CPT Code:	Units requested: