

Behavioral Health Service Request Form

Psychological and Neuropsychological Testing

Please Submit to the Dedicated Fax Line Below

Medicaid

Missouri 866-946-2052

Place of Service 11- Office 22- Outpatient Hospital 53- Community Mental Health Center

Service Request Start Date: _____ Is this a post service request? Yes No

MEMBER INFORMATION

Last Name	First Name, Middle Initial	Date of Birth	
Phone Number	WellCare ID Number	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Third Party Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <small>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.</small>		Languages Spoken

TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name	First Name	NPI Number	
WellCare ID Number	Participating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discipline/ Specialty
Street Address	City, State	ZIP	
Phone Number	Fax Number	Office Contact	

FACILITY/AGENCY INFORMATION

Name	Facility ID	NPI Number	
Street Address	City, State	ZIP	
Phone Number	Fax Number	Office Contact	

Service Type Requested	List CPT Code(s)	List the Specific Tests/Scales Required	Units / Hours Requested per Test
Psychological Testing			
Neuropsychological Testing			

Total number of hours requested for all tests: _____

DIAGNOSIS – Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Problems	

Are services requested court ordered? Yes No *If yes please submit a copy of the court order and all supporting documentation.*

SYMPTOMS/FUNCTIONAL IMPAIRMENTS OF CONCERN

<p>What are the symptoms/functional impairments of concern?</p> <p>Attach additional notes or a copy of diagnostic interview if needed.</p>	
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TESTING RESULTS ACTION *Required***

<p>How will the testing results impact the decision regarding treatment options?</p>	
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RATIONALE FOR REQUEST

Testing referral source:

<input type="checkbox"/> Court/DJJ	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Parent	<input type="checkbox"/> School
<input type="checkbox"/> PCP	<input type="checkbox"/> State Agency
<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Other (Please specify)

What is the overall clinical question that needs to be answered by the requested testing?

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Has the member had an evaluation by a psychiatrist? If so, by whom and when? If not, why not?

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Has the member had a diagnostic interview? If yes, date of interview? Name and credentials of provider who completed the interview?

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Why can't the questions at hand be answered by the diagnostic interview, a review of the member's record or a second opinion instead of testing?

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Has the member had testing before? If so, by whom and when?

PREVIOUS TREATMENT

Type	Frequency	Duration	Provider (if known)

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Adherent?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No