AmeriHealth Caritas New Hampshire

Psychological/Neuropsychological Testing Request

Submit to Utilization Management
Fax: 1-833-469-2264
For assistance, please call 1-833-472-2264

AmeriHealth Caritas New Hampshire requires prior authorization and a medical necessity review for psychological or neuropsychological testing. Use this form to request prior authorization for this testing.

Testing requests must be documented in whole hours, and assessments must justify the clinical need for all tests requested.

Testing will not be authorized under any of the following conditions:

- The referral question can be answered through a comprehensive diagnostic interview and/or routine screening or assessment measure (e.g., self-report inventories or rating scales).
- Testing is not directly relevant or necessary for proper diagnosis and/or development of a treatment plan for a behavioral health disorder or associated medical condition.
- Testing is primarily for educational, vocational, or legal purposes.
- Testing is routine for entrance into a treatment program.
- The tests requested are experimental or have no documented validity.
- The time requested to administer the testing exceeds established time parameters.

Demographic information		
Member name:	Date of birth:	Age:
Referral source:	Medicaid or member ID number:	

Provider information		
Provider name:	Agency name:	
Professional credential: ☐ M.D. ☐ Ph.D. ☐ Other:		
Address:		
Phone:	Fax:	Medicaid/NPI/tax ID:
Date of diagnostic interview/intake: Please attach a summary of the diagnostic interview, including scores from screening tools used.		
Behavioral and medical diagnoses:		
Specific referral reason/question:		
State how the anticipated results of the testing will affect the patient's treatment plan:		
Was a substance use assessment completed? ☐ Yes ☐ No		
Results (or attach the results to this request):		
Has previous psychological or neuropsychological testing been conducted? ☐ Yes ☐ No If yes, please give details to include tests that have been administered, when they were completed, and reason for testing:		

Medications			
Medication name	**Dosage/frequency**	**Start date**	**Prescribing provider**

Testing request			
Start date	**Stop date**	**CPT code**	**Units requested**

Psychological/Neuropsychological Testing Request
Submit to Utilization Management • Fax: **1-833-469-2264**
For assistance, please call **1-833-472-2264**

Please indicate the tests planned to answer the clinical questions			
☐ WAIS (120 min)	☐ MMPI-A (60 min)	☐ ADOS (120 min)	☐ BRIEF (60 min)
☐ Vineland (60 min)	☐ Conner's Continuous Performance — Kiddie (30 min)	☐ Conner's Continuous Performance (60 min)	☐ MACI (60 min)
☐ WPPSI (120 min)	☐ NEPSY (60 min)	☐ MAPI (60 min)	☐ MMPI (60 min)
☐ BASC/CBCL (30 min each) ☐ Self ☐ Parent ☐ Teacher ☐ Other	☐ Autism Checklist (15 min each): ☐ Self ☐ Parent ☐ Teacher ☐ Other	☐ ADHD Checklist (15 min each): ☐ Self ☐ Parent ☐ Teacher ☐ Other	☐ M-FAST:
☐ DAS (60 min)	☐ PAI (60 min)	☐ PAI (60 min)	☐ Other:
☐ Other:	☐ Other:	☐ Other:	☐ Other:
If you are requesting more time for a test than is the standard allowed time, please indicate the reason:			
Additional comments:			

Provider signature: Date: