BEACON HEALTH OPTIONS PSYCHOLOGICAL TESTING REQUEST FORM

Use of testing is encouraged only where clearly indicated and medically necessary. Testing will be authorized only after thorough clinical evaluation fails to resolve questions that have implications for treatment for covered conditions. Receipt of this completed request and subsequent authorization must occur prior to testing. In the event of extreme urgency, call Beacon Health Options 1-800-804-5008. ***Fax this form to 719-538-1439****.*

DATE OF REQUEST: _____

Treating Practitioner Requesting Evaluation

Name: _____ Phone# _____

Address: _____

Member's Length of time in Treatment & Modality: _____
(example: 4 months in op counseling)

Client Information:

First/Last Name: _____

Medicaid # _____ DOB:_____

Guardian's Name & Phone #: _____

Does member need testing in a language other than English? _____Yes _____No

If yes, which language: _____

Axis I: _____ Axis II _____

Axis III: _____

Axis IV: _____ Axis V: _____

1) ***Current symptoms and duration of symptoms***:

2) What are the referral questions and why is testing being requested at this time?

3) History of patient (i.e., psych testing results, psychiatric/neurological exams)

4) Describe how proposed testing will enhance treatment and impact future behavioral treatment

5) Are there any clinical explanations other than psychological ones that could explain current behaviors/sxs? (i.e, thyroid conditions, closed head injury).

6) ***Has member been evaluated by a psychiatrist? Current meds***.

Do you have a preference for who administers psychological testing? _____Yes _____No

If yes, please list your preference and/or special considerations: _____

_____ Fax # _____

Signature of treating practitioner requesting testing Fax # to send testing results

<u>To be completed by Testing Psychologist</u>:

Specific tests proposed:

	<u>Test</u>	<u>Purpose</u>	<u>Units</u>
1.			
2.			
3.			
4.			
5.			

Estimated dates of Conducting Evaluation: _____

Name: _____ Phone# _____

Address: _____

Fax #: _____

_____

Signature of Psychologist Administering Testing

****NEW** PLEASE FAX COMPLETED PSYCHOLOGICAL TESTING RESULTS TO 719-538-1439**