PSYCHOLOGICAL TESTING PREAUTHORIZATION REQUEST

DATE	INSURED'S EMPLOYER		
PATIENT LAST NAME	FIRST NAME	DATE OF BIRTH	AGE
REFERRED BY	PHONE NUMBER		

PREVIOUS PSYCHOLOGICAL TESTING? Yes ☐ No ☐

If Yes, list the date completed:

PSYCHIATRIC EVALUATION? Yes ☐ No ☐

If Yes, list the date completed:

PROVIDER INFORMATION:

PROVIDER NAME	OFFICE CONTACT PERSON	PHONE	FAX

NAME/LICENSURE OF PERSON ADMINISTERING PSYCHOLOGICAL TESTS

HAVE YOU COMPLETED A CLINICAL ASSESSMENT OF THE PATIENT?

Yes ☐ No ☐

DSM-5 DIAGNOSIS:

OTHER DIAGNOSES UNDER CONSIDERATION:

SPECIFY ALL DIAGNOSTIC AND/OR CLINICAL QUESTIONS TO BE ANSWERED:

CURRENT PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST:

LIST EACH TEST USING THE COMPLETE NAME. TESTING TIME MUST BE ONLY TIME SPENT DIRECTLY WITH THE PATIENT.

TESTS:	**TESTING TIME:**
TOTAL TESTING TIME	

Provider Signature **Date**

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