PSYCHOLOGICAL TESTING SUPPLEMENTAL FORM

Provide specific information in context of each unique medical necessity criteria which are available on Beacon's website, in the provider manual.

IDENTIFYING INFORMATION		
Dates of Service Requested: (Start Date)	(End Date)	
Member First Name:	Member Last Name:	MI:
Date of Birth (MM/DD/YYYY):		

RELEVANT DIAGNOSTIC DATA

Relevant results of imaging or other diagnostic procedures (provide dates for each): ☐ None

ASSESSMENT PLAN AND HISTORY

Psychological Test Evaluation Services		Psychological Test Administration and Scoring	
Please select number of units requested		*Please select enter number of units requested*	
Psychological Testing Evaluation Services, 1st hour	**96130**	Test Admin by **Professional**, first 30 minutes	**96136**
Additional hour	**96131**	Additional 30 minutes	**96137**
		Test Admin by **Technician**, first 30 minutes	**96138**
		Additional 30 minutes	**96139**

What suspected or confirmed factors suggest that assessment may require more time relative to test standardization samples:

- ☐ Low frustration tolerance
- ☐ Suspected processing speed deficits
- ☐ Vegetative symptom
- ☐ Performance Anxiety
- ☐ Grapho-motor deficits
- ☐ Receptive communication difficulties
- ☐ Depressed mood
- ☐ Physical symptoms or conditions (such as): ____
- ☐ Other (please specify):____

Why is this assessment necessary at this time:

- ☐ Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms; and ruling out potential comorbidities.
- ☐ Results will help formulate or reformulate a comprehensive and optimally effective treatment plan.
- ☐ Assessment of treatment response or progress when the therapeutic response is significantly different than expected.
- ☐ Evaluation of a member's functional capability to participate in health care treatment
- ☐ Determine the clinical and functional significance of brain abnormality.
- ☐ Dangerousness Assessment
- ☐ Assess mood and personality characteristics impact experience or perception of pain.
- ☐ Other (describe):____

Has a standard clinical evaluation been completed in the past 12 months? ☐Y ☐N

If yes, when and by whom:

If no, explain why a standard clinical evaluation cannot answer the assessment questions:

Date of last known assessment of this type: ☐ No prior testing

If testing in past year, why are these services necessary now:

- ☐ Unexpected change in symptoms
- ☐ Previous assessment is likely invalid
- ☐ Evaluate response to treatment
- ☐ Other (please specify):____
- ☐ Assess function

Are units requested for the primary purpose of differentiating between medical, psychiatric conditions, learning disorders and/or guiding health care services? ☐Y ☐N

Are the units requested for the primary purpose of determining special needs educational programs? ☐Y ☐N

Are the units requested to answer questions of law under a court order? ☐Y ☐N

Currently known symptoms and functional impairments of the patient that warrant this assessment:

RELEVANT MENTAL HEALTH/SUD HISTORY

Relevant Mental Health History: ☐ None

Is substance use disorder suspected? ☐Y ☐N | If yes, how many days of sobriety:

Are medication effects a likely and primary cause of the impairment being assessed? ☐Y ☐N

If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly? ☐Y ☐N

If no, explain why testing is necessary:

If the primary diagnosis is ADHD, indicate why the evaluation is not routine:

- ☐ Previous treatment(s) have failed and testing is required to reformulate the treatment plan
- ☐ A conclusive diagnosis was not determined by a standard examination
- ☐ And/or specific deficits related to or co-existing with ADHD need to be further evaluated
- ☐ Other (please specify):____

Signature of Requesting Clinician: ______________________ Date: __________

Printed Name and Credentials: ______________________