meridian

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Outpatient Psychological Testing Authorization Request Form

Please print clearly. Incomplete or illegible forms will delay processing.
Submit completed form to fax number 833-655-2191.

Date:		
Patient Information	**Provider Information**	
Name:	Provider Name:	
Date of Birth:	Provider Tax ID:	
Member ID:	Provider NPI:	
Health Plan Name:	Phone:	Fax:
For Foster Care Children Only		
Is this request court ordered?	☐ Yes ☐ No	
Is this request required for placement?	☐ Yes ☐ No	
Is this request mandated by the state's Child Welfare/ Foster Care Agency?	☐ Yes ☐ No	
Current ICD Diagnosis		
The provider must report all diagnoses being considered for this patient:		
Primary:	R/O:	R/O:
Secondary:		
Tertiary:		
Additional:		
Additional:		
Danger to self or others? ☐ Yes ☐ No If yes, please explain.		
MSE within normal limits? ☐ Yes ☐ No If no, please explain.		

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Current symptoms prompting request for testing:		
☐ Anxiety	☐ Self-injurious behavior	☐ Depression
☐ Eating Disorder symptoms	☐ Withdrawn/poor social interactions	☐ Poor academic performance
☐ Mood instability	☐ Behavior problems at home	☐ Psychosis/Hallucinations
☐ Behavior problems at school	☐ Bizarre Behavior	☐ Inattention
☐ Unprovoked agitation/aggression	☐ Hyperactivity	☐ Other:

What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing impact the care and treatment in a meaningful way?

History

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past? ☐ Yes ☐ No

Comments:

Does the patient have a family history of psychiatric disorders, behavior problems or substance use disorder? ☐ Yes ☐ No ☐ Uncertain

Comments:

Is there any known or suspected history of physical or sexual abuse or neglect?

☐ Yes ☐ No ☐ Uncertain

Comments:

If ADHD is a diagnostic rule out, please complete the following is the patient's presentation on intake consistent with ADHD? ☐ Yes ☐ No

Indicate the result of Conner's or similar ADHD rating scales, if given:

☐ Positive ☐ Negative ☐ Inconclusive ☐N/A

If the patient is a child, please indicate any information on the patient's cognitive/academic functioning obtained from the school (i.e. teacher feedback, results of school standardized testing):

Date of diagnostic interview:

Has the patient had a psychiatric evaluation? ☐ Yes ☐ No If yes, date?
Previous psychological testing? ☐ Yes ☐ No If yes, date?
Basic focus and results:
Current psychotropic medications:

Please list the tests planned to answer the clinical question(s):	
1.	2.
3.	4.
5.	6.

Please indicate the number of units requested to complete tests:

Please attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

Completed forms can be faxed to 833-655-2191. If you have questions, please contact Meridian's Utilization Management department at 312-980-0440. Representatives are available Monday through Friday, 8 a.m. to 5 p.m. EST. Thank you!

Provider Signature: _____

Date:_____

Provider Signature: _____

Date:_____