## MaineHealth Accountable Care Organization

## Behavioral HealthCare Program

**110 Free Street, Portland, ME 04101 – 800-538-9698 – (Fax) (207) 761-3079**

**PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST**

**This form is applicable only for requests related to the treatment of a mental health disorder. Any medical requests should be directed to the medical plan of the member’s insurance plan. This form is not applicable for any neuropsychological testing requests for Martin’s Point USFHP.**

**Member Name**: **Member’s DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member ID#:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Testing dates requested: Start**: \_\_\_\_\_\_\_\_\_\_\_ **End:**\_\_\_\_\_\_\_\_\_\_

**Referring Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Case Information/Purpose of the Requested Testing: (*What questions do you want answered with these tests?*)**

**Is testing court ordered?** : **Yes**\_\_\_\_\_ **No**\_\_\_\_\_

**ICD Diagnostic Code Number and DSM 5 Diagnosis (If none currently, enter none”):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychologist Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Facility/Practice Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Degree:** \_\_\_\_\_\_\_ **License #**:\_\_\_\_\_\_\_\_\_\_\_\_\_ **Tax ID#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NPI#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List All Tests Required**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Total Hours of Authorization Requested for:**

**Psychological Testing**

**96130 = \_\_\_\_\_\_\_\_\_ 96131 = \_\_\_\_\_\_\_\_\_ 96136 = \_\_\_\_\_\_\_\_\_ 96137 = \_\_\_\_\_\_\_\_\_**

**Initial Evaluation/Feedback Session Requested:** **CPT Codes: 90791** \_\_\_\_\_\_\_ **90837** \_\_\_\_\_\_\_ **90846** \_\_\_\_\_\_\_

**Provider Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BHCP Only:**

**BHCP Approval:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**