

Request for Authorization: Psychological Testing

New York | Medicaid

This form is for psychological testing requests only. Requests for neuropsychological or autism testing need to be completed on their requisite forms.

Please submit this form electronically using our preferred method via <https://Availity.com>.

General information

Member name:	
Member's date of birth:	Member ID #:
Professional administering testing:	
Provider name, if different than the professional administering the testing:	
Provider phone:	Provider fax:
Provider Tax ID:	Provider NPI:
Provider address:	
Provider email:	
Billing facility/group name:	
Billing facility/group NPI:	Billing facility/group Tax ID:
Billing facility/group address:	
Are services being rendered in person or via telehealth?	
Servicing address:	

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through the NY State of Health, The Official Health Plan Marketplace, visit nystateofhealth.ny.gov or call 855-355-5777.

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Formal psychological testing is neither clinically indicated for routine screening/assessment of behavioral health disorders nor indicated for the administration of brief behavior screening measures and inventories. Such screener measures and inventories are an expected part of a routine and complete diagnostic process. Other than in exceptional cases, a diagnostic interview and relevant screening measures should be completed by the psychologist prior to submitting requests for psychological testing authorization.

Requests for placement purposes, disability evaluations, and forensic purposes are not covered benefits. Requests for educational testing or educational assessment for learning disabilities should be referred to the public school system.

Clinical assessment: Indicate which of the following assessments were completed.

<input type="checkbox"/> Brief inventories and/or screening measures	<input type="checkbox"/> Clinical interview with patient
<input type="checkbox"/> Structured developmental and social history	<input type="checkbox"/> Interview with family members
<input type="checkbox"/> Consultation with the patient's physician	<input type="checkbox"/> Medical evaluation
<input type="checkbox"/> Consultation with the school/other important people	<input type="checkbox"/> Psychiatric and medical history
<input type="checkbox"/> Direct observation of parent-child interactions	<input type="checkbox"/> Review of medical records
<input type="checkbox"/> Family history pertinent to testing request	<input type="checkbox"/> Review of academic records/IEP
Date of diagnostic interview:	

Please include any relevant clinical/medical records to support the testing request.

Clinical information: Indicate the presenting problems, symptoms, and need for testing.

<input type="checkbox"/> Acting out behavior	<input type="checkbox"/> Delusions	<input type="checkbox"/> Disorganization
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Irritability	<input type="checkbox"/> Lethargy
<input type="checkbox"/> Low frustration tolerance	<input type="checkbox"/> Speech and language delays	<input type="checkbox"/> Violence or physical aggression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Distractibility
<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Labile mood	<input type="checkbox"/> Low motivation
<input type="checkbox"/> Other developmental delays	<input type="checkbox"/> Suicidal or homicidal ideation	<input type="checkbox"/> Other (Use space below)
<input type="checkbox"/> Attention seeking		
<input type="checkbox"/> Inattention		
<input type="checkbox"/> Poor attention span		
Other:		

Duration of symptoms:

0 to 3 months 3 to 6 months 6 to 9 months 9 to 12 months Greater than 12 months

Screening measures: Please indicate which screening measures have been administered as part of your initial interview (prior to submitting the testing request).

<input type="checkbox"/> Achenbach	<input type="checkbox"/> BASC	<input type="checkbox"/> CBCL	<input type="checkbox"/> MASC	<input type="checkbox"/> RAD
<input type="checkbox"/> ADHD rating	<input type="checkbox"/> BDI	<input type="checkbox"/> CDI	<input type="checkbox"/> MDQ	<input type="checkbox"/> STAI
<input type="checkbox"/> BAI	<input type="checkbox"/> Brief	<input type="checkbox"/> Conner's	<input type="checkbox"/> PCL-5	<input type="checkbox"/> TSCC
<input type="checkbox"/> Other(s):				
Please note pertinent results of screening measure(s):				

Treatment history: Please provide information regarding treatment history.

	How often does the member receive services?	How long has the member been in treatment?	Is the member still in treatment?	Have the member's symptoms improved?
Mental health therapy:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication management:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
School based services:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other services:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other pertinent information:

Please include any other information that supports the request for psychological testing.

Please attach any relevant medical records and/or clinical diagnostic assessments to support the request for testing.

ICD-10-CM diagnoses under evaluation

Code(s)	Current or provisional	
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional

Rationale for testing

Please describe the rationale for testing.

What current questions cannot be addressed by the clinical interview, review of records, and what screening measures have you already administered?
How will the results of testing impact the course of treatment?

Psychological tests and services requested

For tests with multiple versions, specify which version. If you are administering selected subtests, please indicate which subtests you are administering. Please attach a separate sheet if necessary.

CPT® code(s)	Unit(s) requested	Evaluation services to be completed and test names to be administered
<input type="checkbox"/> 96130 (Only one unit allowed)		
<input type="checkbox"/> 96131		
<input type="checkbox"/> 96136 (Only one unit allowed)		
<input type="checkbox"/> 96137		
<input type="checkbox"/> 96138 (Only one unit allowed)		
<input type="checkbox"/> 96139		
Total units requested:		Total time requested:

Provider Signature: _____
 Date: _____

This form can also be submitted via fax to **844-452-8072** prior to rendering services.