Neuro-Psychological & Psychological Testing Clinical Information Guidelines

***This is a guideline only. Please include all of the following information with the prior authorization request to avoid any delay in processing.***

Member Name: ___________________________ DOB: ___________

Psychologist to perform the Testing: ___________________________

Referral Source: (provider who referred Mbr for testing)

Name: ___________________________ Specialty Type: ___________________________

***Please Fax Form to (414)231-1026

Case Background:
(Include Member specific behaviors and symptoms of concern, assessment/testing history with dates and types of prior evaluation, co-existing medical, psychiatric and substance abuse conditions etc.)

Purpose of Testing:
(Specify referral questions, issues related to differential diagnosis, contributions to the treatment plan)

Please list the possible tests requested (i.e. MMPI-2, Millon Inventories, WAIS, etc.)