QualChoice® HEALTH INSURANCE

Request for Psychological Testing

All psychological testing requests must be pre-authorized using this form. This form should be completed by the provider who has thorough knowledge of the member's current clinical situation and/or treatment history. Please provide any additional materials that may be helpful in reviewing this request.

Section I. Requesting Provider Information

Name of Requesting Provider	Clinic Name	Provider QualChoice ID No.

Contact Person	Phone Number

Clinic Address	City	State	Zip

Requesting Provider Signature	Date Signed (MM/DD/YYYY)

Section II. Patient (Member) Information

Patient's Name (Last, First, MI)	Date of Birth (MM/DD/YYYY)	QualChoice ID No.

Brief Psychiatric History

Date of Diagnostic Interview Completion (MM/DD/YYYY): _____
Please provide results of the Diagnostic Interview with this request.

Section III. Medical History

Diagnosis

Is patient on medication? ☐ Yes ☐ No. If YES, list medications below.

Please list the specific test request(s)

Name and Type(s) of Tests *Please print clearly and be precise when indicating the names or acronyms of the tests to avoid confusion.*	**Time requested per test** *Include administration, scoring, interpretation & reporting*	**CPT code per test** *Is testing mainly neuropsychological?* ☐ Yes ☐ No

Section IV. Instructions

Mail: QualChoice Attn: Care Management PO Box 25610 Little Rock, AR 72221	**Fax:** 833.681.2498