

QUEST BEHAVIORAL HEALTH
REQUEST FOR PSYCHOLOGICAL TESTING AUTHORIZATION

Date _____ Patient Name _____ DOB _____

Social Security # _____ Employer Group: _____

Previous Testing No ___ Yes ___ If yes, when _____

Psychological testing is a highly specialized component of the process of clinical assessment. It may be authorized under the mental health benefit only when data necessary for diagnosis and/or treatment planning is unavailable by other means of assessment (e.g., clinical interview, relevant history review, application of DSM-IV criteria, structured checklists, consultations with other treating providers, interviews with parents, teachers, review of school records, etc.)

Clinician: _____ Phone # _____ Fax # _____

Psychologist License Number: _____

Office/Group: _____ Location: _____

Current Diagnosis: _____

Current Meds: _____

Patient's current symptoms _____

Referral Question(s) (Please state the **specific** clinical questions you want the psychological testing to address.) _____

Please list **all** you have done to answer these questions prior to requesting the psychological testing.

How will testing aid the patient's care? _____

Tests Requested

Time Requested

Is the patient or legal guardian in agreement with the administration of these tests? YES NO

(For QUEST use only) _____ Approved/Date _____

_____ Denied/Date _____

Reason for Denial: _____
