BlueCross BlueShield of North Carolina MEDICARE

Request for Authorization: Psychological Testing

Please note, this form applies to Healthy Blue + Medicare℠ (HMO D-SNP) offered by Blue Cross and Blue Shield of North Carolina [(Blue Cross NC)].

Please submit this form electronically using our preferred method at **https://www.availity.com**.* This form can also be submitted via fax to **844-430-1703**.

General information

Member name:			
Member DOB:		Member ID:	
Psychologist name:			
Provider ID #:		Provider email:	
Provider phone:		Provider fax:	

Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders, or for the administration of brief behavior rating scales and inventories. **Such scales and inventories are an expected part of a routine and complete diagnostic process.** Other than in exceptional cases, a diagnostic interview and all relevant rating scales should be completed by the psychologist prior to submission of requests for psychological testing authorization. Requests for placement and forensic purposes are not covered benefits. Requests for educational testing and assessment of learning disabilities for educational purposes should be referred to the public school system.

Clinical assessment — Indicate which of the following assessments have been completed:

☐ Clinical interview with patient	☐ Brief inventories and/or rating scales
☐ Interview with family members	☐ Structured developmental and social history
☐ Medical evaluation	☐ Consultation with patient's physician
☐ Psychiatric and medical history	☐ Consultation with school/other important persons
☐ Review of medical records	☐ Direct observation of parent-child interactions
☐ Review of academic records/IEP	☐ Family history pertinent to testing request

Clinical information — Indicate which of the following problems and symptoms present a need for testing:

☐ Acting out behavior	☐ Hallucinations	☐ Low frustration tolerance
☐ Anxiety	☐ Impulsivity	☐ Other developmental delays
☐ Attention seeking	☐ Inattention	☐ Poor attention span
☐ Delusions	☐ Irritability	☐ Speech and language delays
☐ Depression	☐ Labile mood	☐ Suicidal or homicidal ideation
☐ Disorganization	☐ Lethargy	☐ Violence or physical aggression
☐ Distractibility	☐ Low motivation	☐ Other (Use space below for other.)
Other:		

Duration of symptoms: ☐ 0 to 3 months ☐ 9 to 12 months ☐ 3 to 6 months ☐ 6 to 9 months ☐ Greater than 12 months

Availity, LLC is an independent company providing administrative support services for Healthy Blue + Medicare providers on behalf of Blue Cross and Blue Shield of North Carolina.

https://www.bluecrossnc.com/providers/blue-medicare-providers/healthy-blue-medicare

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Treatment history — Provide information regarding treatment history:

	Frequency	Duration of treatment	Is member still in treatment?	Have symptoms improved?
Individual therapy:			☐ Yes ☐ No	☐ Yes ☐ No
Medication management:			☐ Yes ☐ No	☐ Yes ☐ No
School/home-based management:			☐ Yes ☐ No	☐ Yes ☐ No
Other services:			☐ Yes ☐ No	☐ Yes ☐ No
Date of diagnostic interview:				

Rating scales — Indicate which rating scales have been administered as part of your clinical assessment:

☐ Achenbach	☐ BASC	☐ CBCL	☐ MASC	☐ RAD
☐ ADHD rating	☐ BDI	☐ CDI	☐ MDQ	☐ STAI
☐ BA	☐ Brief	☐ Conner's	☐ PCL-5	☐ TSCC
☐ Other:				

Note pertinent results of rating scales:

Other pertinent information — Include any other information that supports the request for psychological testing.

Previous psychological testing — Include any information regarding previous psychological testing (such as dates of testing or results) and why retesting is requested.

***DSM-5/ICD-10* diagnoses**

Rationale for testing — Describe the rationale for testing. What are the current questions to be answered that cannot be addressed by the clinical interview, review of records and rating scales that you have already administered? How will the results of testing impact the course of treatment?

Is this a request for a trauma assessment? ☐ Yes ☐ No

Psychological tests and services requested

CPT® code(s)	Units requested	Test names/service description

Total units requested:		Total time requested:	

Provider signature:		Date:	

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

☐ By checking this box, I hereby certify that the protected health information (PHI) contained in the correspondence received in error has been destroyed and has not otherwise been retained, utilized, or further disclosed. In the event the PHI must be retained it will further be protected until the time it can be destroyed.