Request for Medical Appropriateness Determination for Psychological Testing Form

FOR PROVIDER USE ONLY

7231 Parkway Drive, Suite 100
Hanover, MD 21076

***Date:**

Member Information:		
Member name:	DOB:	Member ID#:*(not SSN)*
Policyholders name:	Policy (EHP,USFHP)	Members Relationship to Policyholder
Member Address:		
Psychologist Information:		
Name of Psychologist:	Network ☐ Non-Network ☐	Tax ID Number
Address:	Degree/State License and Number	
City/State/Zip	Are you independently licensed? ☐ Yes ☐No	
	Phone #:	
Therapist Information: (If different from above)		
Name of Therapist:	Network ☐ Non-Network ☐	Tax ID Number
Address:	Degree/State License and Number	
City/State/Zip	Are you independently licensed? ☐ Yes ☐ No	
	Phone #:	
Services		
A. (i.) Who initiated referral? (If MD, what is MD's specialty)		
(ii.) What are the referral questions?		

B. Current possible DSM-5 diagnoses under evaluation:

Code:	Description:
_____	_____
_____	_____
_____	_____

C. History of patient (Summary of psychosocial and medical information (with examination dates and past treatment: Include any past psychological testing, date and results):

D. Describe specifically how proposed testing will impact psychological treatment:

E. List test (s) planned and time required – Write full name of the test –please do not abbreviate. Estimated Hours Required /Specific Test Planned

I. Intelligence

II. Academic/Vocational

I. Psychological/Social

II. Neuropsychological/Other

CPT Codes Requesting: _____ Total Time Required: _____