Cenpatico Psychological Testing Authorization Request Form
OUTPATIENT

***ALL FIELDS MUST BE COMPLETED FOR THIS REQUEST TO BE REVIEWED**
(Please type or print neatly)

I. Identifying Information

Patient's Name:_____________________________ **Medicaid #:**_________________**DOB:** _________________

Provider's Name:_________________________________ **Group Name:** _______________________________

Provider's Phone Number:____________________________ **Fax:** _______________________________________

Provider TIN/ NPI #: ____

Referral Source: ____

II. Provisional DSM-5 Diagnoses- *The provider must report all diagnoses being considered for this patient.

Axis I ____
Axis I ____
Axis I ____
Axis I ____
Axis I R/O____

Danger to Self or Others (If yes, please explain)? **YES** **NO** ______________________________________

MSE Within Normal Limits (If no, please explain)? ☐ **YES** ☐ **NO** ______________________________________

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III. What are the current symptoms prompting the request for testing?

- ☐ **Anxiety Self-injurious Behavior**
- ☐ **Depression**
- ☐ **Withdrawn/poor social interaction**
- ☐ **Mood instability**
- ☐ **Psychosis/Hallucinations**
- ☐ **Bizarre Behavior**
- ☐ **Unprovoked agitation/aggression**
- ☐ **Other:** ________________________________
- ☐ **Eating disorder symptoms:** ____________________
- ☐ **Poor academic performance**
- ☐ **Behavior problems at home**
- ☐ **Behavior problems at school**
- ☐ **Inattention**
- ☐ **Hyperactivity**

Cenpatico is Buckeye Community Health Plan's MyCare Ohio (a Medicare-Medicaid Plan) behavioral health affiliate. Buckeye has delegated managing the provision of covered mental health and substance use disorder services to Cenpatico.

Have Questions?
Call us at 1-866-549-8289

www.cenpatico.com

IV. What is the question to be answered by testing that cannot be determined by a diagnostic interview, review of psychological/psychiatric records or collateral information? How will testing affect the care and treatment in a meaningful way? ______________________________

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V. History:

Does the patient have any significant medical illnesses, history of developmental problems, head injuries or seizures in the past? ☐ YES ☐ NO Comments: ______________________________

Does the patient have a family history of psychiatric disorders, behavior problems or substance use disorder?
☐ YES ☐ NO ☐ UNCERTAIN Comments: ______________________________

Is there any known or suspected history of physical or sexual abuse or neglect?
☐ YES ☐ NO ☐ UNCERTAIN Comments: ______________________________

If ADHD is a diagnostic rule out, please complete the following: Is the patient's presentation on intake consistent with ADHD? ☐ YES ☐ NO

Indicate the results of Conner's or similar ADHD rating scales, if given:
☐ POSITIVE ☐ NEGATIVE ☐ INCONCLUSIVE ☐ N/A

If the patient is a child, please indicate the collateral information you have obtained from the school regarding cognitive/academic functioning (i.e., teacher feedback, results of school standardized testing)?

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Date of Diagnostic Interview: ______________________________

Has the patient had a Psychiatric Evaluation? ☐ YES ☐ NO
If yes, date of the interview: ______________________________

Previous Psychological Testing? ☐ YES ☐ NO
If yes, date? ______________________________
Basic Focus and Results: ______________________________

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Current Psychotropic Medications: ______________________________

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VI. Please List the Tests Planned to Answer the Clinical Question(s)

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

VII. Please indicate the number of units requested to complete tests: ____________________

______________________________	______________________________
Clinician's Signature/Title	**Date**

SUBMIT TO:

Utilization Management Department 12515-8 Research Blvd., Suite 400
Austin, TX 78759
Phone: 800-224-1991
Fax: 877-725-7751

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