AmeriHealth Caritas VIP Care

# Neuropsychological Testing Request ☐
# Psychological Testing Request ☐

**Please check one of the boxes above.**

**Please type or print clearly. Incomplete and illegible forms will delay processing.**

**When complete, fax to:**

| **Please use the fax number listed below that corresponds to the state where the AmeriHealth Caritas VIP Care plan operates.** | | | | | |
|---|---|---|---|---|---|
| Delaware | Florida | Louisiana | Michigan | North Carolina | Pennsylvania |
| **1-866-329-3324** | **1-833-329-3524** | **1-866-565-2583** | **1-855-329-6400** | **1-833-362-7262** | **1-855-396-5750** |

## 1. Member information

| | | | |
|---|---|---|---|
| Member name: | Eligibility ID #: | SSN: | DOB: |
| Member address: | City, state, ZIP code: | | Phone: |
| Who referred member for treatment? | | | |

## 2. Treating provider information

| | | | |
|---|---|---|---|
| Name (with credentials): | NPI #: | Phone: | |
| Address: | City, state, ZIP code: | | Fax: |
| Group name or ID number: | Contact name: | Treating provider signature: | |

## 3. Testing requested

☐ **Neuropsychological:** Insert service codes being requested:

☐ **Psychological:** Insert service codes being requested:

Referral reason and functional impairment:

How will the anticipated results affect the member's treatment plan?

## 4. DSM-5 diagnosis

List all mental health, substance use, and medical diagnoses:

## 5. Current symptoms prompting request for testing

| | | |
|---|---|---|
| ☐ Anxiety<br>☐ Psychosis or hallucinations<br>☐ Mood instability<br>☐ Bizarre behavior<br>☐ Inattention | ☐ Hyperactivity<br>☐ Withdrawal or social isolation<br>☐ Unprovoked agitation or aggression<br>☐ Self-injurious behaviors<br>☐ Eating disorder symptoms | ☐ Behaviors impacting activities of daily living (ADLs)<br>☐ Depression<br>☐ Poor academic or employment performance<br>☐ Other: _____ |

## 6. Current medications

List with dosages or attach sheet:

## 7. Assessments to date

| | |
|---|---|
| ☐ No assessment procedures performed to date<br>☐ Direct observation<br>☐ Assessment by mental health professionals<br>☐ Consultation with others<br>☐ Structured interview<br>☐ Interview with family or guardians | ☐ Medical evaluation<br>☐ Review of records of previous treatment<br>☐ Clinical interview with patient<br>☐ Brief inventories or rating scales<br>☐ Consultation with patient's provider<br>☐ Other (please list): _____ |

# Neuropsychological/Psychological Testing Request

**Please answer the following. Attach additional pages and records if necessary.**

Patient medical and psychiatric history: _____

Family medical and psychiatric history: _____

Describe any neurological events and/or neuro-developmental concerns: _____

History of psychological testing and results or findings: _____

| **8. Description of testing request** | | |
|---|---|---|
| **Test to be administered** | **Time required** (administration of test, scoring, interpretation, and report preparation) | **Comments** |
| | | |
| | | |
| | | |
| | | |

**Additional information**