Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Psychological Testing Prior Authorization Form

Fax to: **1-866-366-7008** Telephone: **1-844-835-4930**

Clear Form

A determination will be communicated to the requesting provider.
Incomplete requests will delay the prior authorization process.

TYPE OF REQUEST

☐ **URGENT:** When a 7 calendar day non-urgent prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or the delay in treatment would subject the member to potential harm.

☐ **NON-URGENT:** For routine services and a response within 7 calendar days.

☐ **COMPREHENSIVE ASSESSMENT PLANNING SYSTEM (CAPS)**: This request is for a mental health evaluation and psychological testing as required by the State. The evaluation and psychological testing are permitted to be scheduled on the same day. Please add CPT codes and the number of units below.

☐ **Court Ordered or CPS Request**

PATIENT INFORMATION

Patient Name: Last First MI				**Date of Birth:**
I.D. #:		**Gender:** ☐ Male ☐ Female		**EPSDT Special Service Request?**
Other Insurance? ☐ Yes ☐ No	**Name of Carrier:**	**Job Related?** ☐ Yes ☐ No	**MVA?** ☐ Yes ☐ No	**Is the member currently pregnant?** ☐ Yes ☐ No

FROM - REQUESTING PROVIDER

Requesting Provider (Please print):			**Tax ID #:**
Contact Person in Requesting Provider's Office:	**Telephone:**	**Fax:**	**WV Medicaid Provider #:**
Clinical Contact Person: **Phone:**	**Name of PCP:**		

WHERE WILL PATIENT RECEIVE SERVICES?

Physician/Provider/Facility Requested:	**Address:**	**Telephone:**	**Fax:**
Where services will be rendered? (Provide name of facility, if other than provider office)			**WV Medicaid Provider #:**
Today's Date:		**Tentative Date of Service/Admission:**	
Were member school-based services interrupted? ☐ Yes ☐ No		**Start Date:** **End Date:**	

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CLINICAL INFORMATION	
ICD-10 Codes: **1) 2) 3) 4)**	**ICD-10 Description:**
CPT/HCPCS Codes: **1) 2) 3) 4)**	**CPT/HCPCS Description:**
List number of days/visits/units, or if services are needed at discharge:	

Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders, nor is it indicated 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. A diagnostic interview and relevant rating scales should be completed by the practitioner prior to submitting requests for psychological testing, unless there are extenuating circumstances. Psychological testing requests for placement and forensic purposes are not a covered benefit. Psychological testing requests for educational testing, or learning disabilities assessment should be referred to the member's public school system.

CLINICAL ASSESSMENT			
Date of diagnostic interview: _____			
Indicate which of the following assessments have been completed.			
☐ Psychiatric and medical History Date completed: _____	☐ Clinical interview with Patient Date completed: _____	☐ Structured developmental and social history Date completed: _____	☐ Direct observation of parent-child interactions Date completed: _____
☐ Family history pertinent to testing request Date completed: _____	☐ Interview with family Members Date completed: _____	☐ Consultation with school/other important persons Date completed: _____	☐ Medical evaluation Date completed: _____
☐ Consultation with member's practitioner Date completed: _____	☐ Brief inventories and/or rating scales Date completed: _____	☐ Review of medical Records Date completed: _____	☐ Review of academic records/IEP Date completed: _____

Indicate which of the following problems and symptoms presented a need for testing.				
☐ Inattention	☐ Irritability	☐ Disorganization	☐ Depression	☐ Anxiety
☐ Labile mood	☐ Lethargy	☐ Low motivation	☐ Distractibility	☐ Impulsivity
☐ Poor attention span	☐ Acting out behavior	☐ Attention seeking	☐ Hallucinations	☐ Delusions
☐ Low frustration tolerance	☐ Suicidal/homicidal ideation	☐ Violence/physical aggression	☐ Speech and language delays	☐ Developmental delays
☐ Other:		Duration of Symptoms: ☐ 0-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months ☐ >12 months		

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TREATMENT HISTORY

Please provide information regarding treatment history.

	Frequency	Duration of treatment	Is the member still in treatment?	Have symptoms improved?
Individual therapy:				
Medication management:				
School or home - based treatment:				
Other services:				

SUBSTANCE USE HISTORY

Substance	Date of Last Use	Frequency	Amount Used

RATING SCALES

Please indicate which rating scales have been administered as part of your clinical assessment.

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

Please include pertinent results of rating scales:

OTHER PERTINENT INFORMATION

Please include any other information that supports the request for psychological testing:

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PREVIOUS PSYCHOLOGICAL TESTING
Please include any information regarding pervious psychological testing (e.g.; dates of testing, results) and why retesting is considered necessary:
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 request for a trauma assessment? ☐ Yes ☐ No
PSYCHOLOGICAL TESTS REQUESTED
Please list the test(s) you are requesting and the administration time for each one:
Total time requested in hours:

Practitioner Signature: _____ **Date:** _____