PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

This is a request for psychological testing. Once complete, fax this form to 720-744-5130.

Date of request:

Member name:	Member date of birth:

Medicaid number:

Provider name:

Provider phone:	Provider fax:

Agency/provider to complete testing:

License number of testing psychologist:	Agency/testing provider fax:

Code requested	Total # of hours requested	Estimated hour breakdown	
☐ 96101 ☐ 96102 ☐ 96103		Test administration	
		Result interpretation	
		Report preparation	
☐ 96116		Test administration	
		Result interpretation	
		Report preparation	
☐ 96118 ☐ 96119 ☐ 96120		Test administration	
		Result interpretation	
		Report preparation	

1. Describe the symptoms the patient is exhibiting and explain why you are requesting psychological testing:

2. What is the differential diagnosis?

PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM CONTINUED

3. What is it about this case that makes it difficult to make a diagnosis based on the clinical presentation?

4. What questions would you like answered by the psychological testing?

5. Have other consultations been obtained (i.e. primary care provider, psychiatrist, neurologist)? If so, please include their findings.

6. What medications have been tried (include the dosage, length of use, and how effective each trial was):

Medication	Dosage	Period of use	Effectiveness

7. How will the results of the psychological testing change your therapeutic approach?

Please attach a copy of your clinical assessment and results of previous testing.