WellCare
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

Psychological and Neuropsychological Testing

Please Submit to the Dedicated Fax Line Below

New Jersey Medicaid

1-888-339-2677

Place of Service	☐ 11- Office ☐ 22- Outpatient Hospital ☐ 53- Community Mental Health Center ☐ Other:(*Indicate here*)
Service Request Start Date:	**Is this a post service request?** ☐ Yes ☐ No

MEMBER INFORMATION					
Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**WellCare ID Number**		**Gender**	☐ Male ☐ Female
Third Party Insurance	☐ Yes ☐ No	If **Yes**, please attach a copy of the insurance card. If the card is not available, then provide the name of the insurer, policy type and number.		**Languages Spoken**	

TREATING PROVIDER/PRACTITIONER INFORMATION					
Last Name		**First Name**		**NPI Number**	
WellCare ID Number		**Participating**	☐ Yes ☐ No	**Discipline/ Specialty**	
Street Address		**City, State**		**ZIP**	
Phone Number		**Fax Number**		**Office Contact**	

FACILITY/AGENCY INFORMATION					
Name		**Facility ID**		**NPI Number**	
Street Address		**City, State**		**ZIP**	
Phone Number		**Fax Number**		**Office Contact**	

Are all units exhausted? ☐ Yes ☐ No	**If No, indicate amount used:**

Service Type Requested	List CPT Code(s)	List the Specific Tests/Scales Required	Units / Hours Requested per Test
Psychological Testing			
Neuropsychological Testing			
Total number of hours requested for all tests:			

DIAGNOSIS – Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Problems	

Are services requested court ordered? ☐ Yes ☐ No ***If yes, please submit a copy of the court order and all supporting documentation.***

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SYMPTOMS/FUNCTIONAL IMPAIRMENTS OF CONCERN	
What are the symptoms/functional impairments of concern? Attach additional notes or a copy of diagnostic interview if needed.	

TESTING RESULTS ACTION ***Required**	
How will the testing results impact the decision regarding treatment options?	

RATIONALE FOR REQUEST

Testing referral source:

☐	**Court/DJJ**	☐	**Psychologist**
☐	**Parent**	☐	**School**
☐	**PCP**	☐	**State Agency**
☐	**Psychiatrist**	☐	**Other (Please specify)**

What is the overall clinical question that needs to be answered by the requested testing?

Has the member had an evaluation by a psychiatrist? If so, by whom and when? If not, why not?

Has the member had a diagnostic interview? If yes, what is the date of interview? Please provide the name and credentials of provider who completed the interview.

Why can't the questions at hand be answered by the diagnostic interview, a review of the member's record or a second opinion instead of testing?

Has the member had testing before? If so, by whom and when?

Psychological testing will be administered by provider whose qualifications are appropriate to proposed assessment. ☐**Yes** ☐**No**

Who will the information obtained from the testing be shared with for coordination of care?

Will the member's family/support system (teacher; caregiver) be engaged in the testing or treatment indications? ☐**Yes** ☐**No**

PREVIOUS TREATMENT

Type	Frequency	Duration	Provider (if known)

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Adherent?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No