**CONFIDENTIAL** **American Behavioral** ® **CONFIDENTIAL**

**Psychological Testing Request**

**Fax to: (205) 868-9625**

Patient Name: ______________________________________________

Patient ID #: ___________________________ Patient DOB: ___________________________

*Subscriber* Place of Employment: ______________________________________________

Office Contact: ______________________ Phone #: ______________ Fax #: ______________

Testing Date: ______________ Testing Psychologist: ______________________________

**Address Where Testing Will be Performed:** ______________________________________

| CPT Code | Rule In/Rule Out | # of Hours Allowed |
|---|---|---|
| **96101**<br>**Administered By a Psychologist ONLY**<br><br>Please check the appropriate box if you wish to rule in or rule out the following diagnoses: | ☐ Depression & Anxiety Versus AD(H)D | 4 |
| | ☐ Depression & Anxiety Versus Bipolar Spectrum Disorder | 4 |
| | ☐ Depression & Anxiety Versus Dementia or TBI | 5 |
| | ☐ Depression & Anxiety Versus Oppositional/Defiant Disorder Versus AD(H)D | 4 |
| | ☐ Intermittent Explosive Disorder Versus Bipolar Spectrum Disorder | 4 |
| | ☐ Substance-induced Agitation Versus Bipolar Spectrum Disorder | 4 |
| | ☐ Personality Disorder Versus Psychosis | 4 |
| | ☐ Failure to Improve in Treatment | 3 |
| | ☐ Failure to Improve in Treatment Versus OBS | 2 |
| | ☐ Oppositional/Defiant Disorder Versus AD(H)D | 3 |
| | ☐ AD(H)D Versus Learning Disability | **Refer to the school system for an educational assessment** |
| | ☐ Bipolar Spectrum Disorder Versus AD(H)D | 3 |
| | ☐ Bipolar Spectrum Disorder Plus AD(HD) | 3 |

| CPT Code | # of Hours Requested | ***Name and Credentials*** **of Administering Technician** **OR** **Name(s) of Computerized Test(s) To Be Administered** |
|---|---|---|
| **96102**<br>(Psychological Testing **Administered by a Technician** With Qualified Health Care Professional Interpretation and Report) | | |
| **96103**<br>(Psychological Testing **Administered by a Computer** With Qualified Health Care Professional Interpretation and Report) | | |

**Detailed clinical symptoms:** ______________________________________________

______________________________________________________________________

______________________________________________________________________

**How will the testing affect treatment?** ______________________________________

______________________________________________________________________

______________________________________________________________________

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**Revised 01-31-12; Supersedes Revision(s) Dated: 01-06-10; 10-20-09; 02-19-10; 04-01-10; 04-29-10; 03-04-11; 04-19-11**

Patient Name: ___________________________________________________________ Patient ID #: ________________________________

Testing Psychologist: ________________________________________________________________________________________

*********************************NONCOVERED SERVICES*********************************

**Neuropsychological testing, as well as achievement, aptitude, IQ, occupational and learning disability assessments are usually non-covered benefits. If you wish to administer any of these tests/assessments, please include additional detailed information with this form.**

**Please List Specific Reasons for Testing and Requested Tests Not Mentioned on Page One**

| Rule In/Rule Out | Tests(s) | # of Hours Requested |
|---|---|---|
| | 1. ____________________ | 1. __________ |
| | 2. ____________________ | 2. __________ |
| | 3. ____________________ | 3. __________ |
| | 4. ____________________ | 4. __________ |
| | 5. ____________________ | 5. __________ |
| | 6. ____________________ | 6. __________ |
| | 7. | 7. |

***************************FOR AMERICAN BEHAVIORAL USE ONLY***************************

| CPT Code | Hours Approved | Authorization # | Start Date | Auth. Expiration Date | Deductible & Amount Applied | Out-of-Pocket Max | Co-insurance | Copay | Coinsurance/ Copay Paid Per Hour or Per Day |
|---|---|---|---|---|---|---|---|---|---|
| **96101** | | | | | | | | | ☐ Per Hour<br>☐ Per Day |
| **96102** | | | | | | | | | ☐ Per Hour<br>☐ Per Day |
| **96103** | | | | | | | | | ☐ Per Hour<br>☐ Per Day |
| **Other** | | | | | | | | | ☐ Per Hour<br>☐ Per Day |

**<u>APPEALS PROCESS:</u> You have the right to appeal this determination through the appeals process which you may access by calling American Behavioral at 877-660-6646. A copy of American Behavioral Managed Behavioral Healthcare Services policies and procedures concerning appeals and a copy of the specific clinical criteria used in this decision are available by request.**

***Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract and payment is subject to retroactive eligibility verification.***

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