Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Request for Psychological Testing

Patient Name:_____ EnrolleeID#:_____ Date of Birth:_____

1. Have you evaluated the member clinically with at least one face-to-face session? Yes___ No___
2. Will you continue to see the patient after testing is completed? Yes___ No___
3. What is the provisional or rule out diagnosis(es)? _____
   _____
4. Are job/school related measures of function available? Yes___ No___ If so, what do they indicate
   _____
   _____
5. Is there collateral information documenting job or school functioning problems? Yes___ No___ If so, what do they indicate?
6. Briefly describe the patient and the clinical issues which need clarification with psychological testing:
   _____
   _____
   _____
   _____
   _____
   _____
7. How will the information gained from the psychological testing impact the patient's treatment plan:
   _____
   _____
   _____
   _____
   _____
   _____
8. Please list the following tests and associated hours for each test. If testing is specific to diagnosing a Learning Disabilities or providing for educational/occupational accommodations please check the box labeled LD/Accommodations. (Please attach additional pages if needed.)

Tests Completed to Date	Hrs	Proposed Tests	Hrs	LD / Accommodations
		Total Hours Requested:		

Person who will be conducting testing: _____	Phone: _____
Address: _____ City: _____ State: ____	Zipcode: _____

Mail form to: CBHA, Box 571137, Winston-Salem, NC 27157-1137 or FAX form to: (888) 908-7140