Request for Psychological Testing

Patient Name: ____ **Enrollee ID #:** ________________________

Please respond to the following questions:

1. Have you evaluated the member clinically with at least one face-face session? Yes__ No__
2. Will you continue to see the patient after testing is completed? Yes__ No__
3. Are job/school related measures of functioning available? Yes__ No__ If so, what do they indicate? ________________
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4. Is there collateral information documenting job or school functioning problems? Yes__ No__ If so, what do they indicate?
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5. Briefly describe the patient and the clinical issues which need clarification with psychological testing:

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6. How will the information gained from the psychological testing impact the patient's treatment plan?

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7. Please list testing that has already been completed and testing that is being requested

Tests completed to date:	Hours	Proposed Tests:	Hours

8. Total hours requested: _________

9. Person who will be conducting this testing:

Name: __________________________________ Phone #: __________________________
Testing Address:____

Form submitted by: ______________________ **Phone #:** ____________ **Date:** ___________________

Mail form to: CBHA, Box 571137, Winston-Salem, NC 27157-1137 or FAX form to: (336) 499-4006

CBHA Review:
Approved _______ **Number of Hours approved:** _______ **Denied** _______

Reviewer Signature: _________________________________ **Title:**___________________ **Date:** ___________________

CBHA – Revised 8/11