Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Request for Psychological Testing

Patient Name:______________________________ Enrollee ID#:______________________ 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 ________________________

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5. Is there collateral information documenting job or school functioning problems? Yes___ No___ If so, what do they indicate?

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6. Briefly describe the patient and the clinical issues which need clarification with psychological testing: ________________________

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7. How will the information gained from the psychological testing impact the patient's treatment plan:

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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: ______________________

Form Submitted by: ________________________ Phone: __________________________ Date: ___________

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