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AETNA BETTER HEALTH® OF KENTUCKY

Psychological and Neuropsychological Testing Request

Fax as a single document to AETNA BETTER HEALTH OF KENTUCKY **1-844-885-0699 or SKY 1-833-689-1424** Before requesting authorization for testing, a **Structured or Semi-Structured Interview and a validated Symptom Inventory or Rating Scale must be completed as part of a face-to-face evaluation**. This documentation may be included with this request to further support the need for testing.

Provider name/credentials (please print)	Provider NPI #	Provider Phone #	Provider Fax #
Member name (please print)	Medicaid ID #	Date of birth / /	Age
Diagnosis ICD-10 (include medical)	R/O Diagnosis:	Referred by (name, specialty, phone)	

Please note the specific tests being administered, the service code being requested, and the time requested to administer, score and report.

Specific Test Requested	Service Code (CPT)	Time Requested	Testing Start Date: / /
			Testing End Date: / /
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			Please note: Requests must
			be received <u>within (2)</u>
			business days of the
			requested start date. The
			maximum timeframe that
			may be requested is (4)
			months.

<u>Please note, the following must be completed in its entirety in order to receive a determination. Failure to complete all sections may result in delay in processing or lack of authorization.</u>

Has there been previous testing? Yes I No I Current Behavioral Health Treatment? Yes No I	Date of Previous Testing: Provider Name:	/ /
How long receiving services ?		
Information sought from past/current providers prior to testing	? Yes 🗆	No 🗆
Pre-testing Assessment		
Face-to-face evaluation performed?	Yes 🗖	No 🗆
Medical or Neurological evaluation within the last 6 months?	Yes 🛛	No 🗆
Member and family psychiatric and medical history explored?	Yes 🗆	No 🗆
Substance use? No history Current/recent	Past (more than 6 months	; ago) 🗆
Information sought from significant others or family members in	n the home? Yes 🛛	No 🗆
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If a child, has the parent/guardian been interviewed?	Yes 🛛	No 🗆	
Interactions between child/parent/caregivers have been observed?	Yes 🛛	No 🗆	
Child observed in natural settings?	Yes 🗆	No 🗆	
Consulted with school personnel and/or other important persons in life?	Yes 🗆	No 🗆	
At least (1) <u>valid rating scale completed prior to testing?</u>	Yes 🗆	No 🗆	
Name of Instrument:			
Structured/Semi-Structured Interview completed prior to testing?	Yes 🗆	No 🗆	
Name of Instrument:			

<u>The following information must be provided in order to receive a determination. Please write legibly.</u> <u>Clinical Data</u>: (include relevant psycho/social/behavioral history, current acute symptoms, impairments in functioning, mental status, etc. Please attach any assessments, evaluations, or other clinical documentation that may support the request.)

<u>Purpose of testing</u> (what is the case-specific question that testing is intended to answer? Nonspecific reasons for testing, such as "for treatment planning," are not adequate.)

How will testing affect member's treatment (what is the specific impact testing will have on treatment?):

If applicable, have resources for testing been explored through the member's school? (If no, explain)

Signature of Provider	Date	
Address	City, State, Zip Code	

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