Halcyon Behavioral
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Admin Phone: (855) HBI-4HLP
Member Phone: (888) 425-4800
Clinical Fax: (888) 304-1429

PSYCHOLOGICAL TESTING REQUEST

Note: testing must be medically necessary and preceded by a thorough clinical assessment for consideration of coverage.

Patient Information

Name: _____

Date of Birth: _____ Age: _____ Sex: □ M □ F

Insurance ID: _____

Group Coverage Through: _____

Provider Information

Name/Title: _____

Office Phone #: _____

Office Fax #: _____

Office Address: _____

Treatment Information

Patient referred on: _____ by: □ PCP □ Psychiatrist □ Therapist □ Neurologist □ Self □ Other _____

Reason Referred for Testing: _____

Has the requesting provider (noted below) completed an initial assessment: □ Yes □ No Diagnosis:_____

If Yes, date(s):_____ If not why? _____

Has the requesting provider (noted below) completed a review of patients clinical records/history? □ Yes □ No

Has there been any prior testing? □ Yes □ No If Yes, were prior testing results/report reviewed? □ Yes □ No

Current Symptoms/Functional Impairments

Current Substance Abuse (If any substance use identified within past 90 days, indicate substance and date of last use)

What is the specific clinical question(s) to be answered by test results?

Please note: Testing that is primarily for research, educational, vocational, forensic, or administrative reasons is not a covered benefit.

Reason clinical questions can't be answered through diagnostic interview, records review, clinical obversation, or other consult?

Tests Requested: (Time Required is inclusive of administration, interpretation, & report writing)

All tests must be necessary to address questions identified above & needed for treatment planning. Attach additional documents if needed.

Test Name (Note "All" Scales or Identify Selected Scales)	Administered By	Time Required

Specific Service(s) Requested:

CPT Code(s): _____ Total Time Requested: _____

My signature below confirms the information provided is accurate and I am providing/interpreting the requested services

Provider Signature: _____ Date: _____