San Diego Public Sector

**Pre-Authorization Request Form For Medi-Cal Psychological Testing**

**Please fax completed form to (866) 220-4495**

**Note:** Psychological testing must be pre-authorized. Requests will be processed within 14 calendar days from date of receipt. An incomplete form may delay processing. Authorizations are based on the client’s Medi-Cal eligibility, Optum Policies & Procedures, and Psychological and Neuropsychological Testing Guidelines. (Questions: (800) 798-2254 Option #3 then Option #4)

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| --- | --- |
| **Name of Client to Receive Testing:** Click to Enter Text | **Client’s DOB:** Click here to enter a date. |
| **Client’s Medi-Cal #:** Click to Enter Text | **Testing Dates of Service Requested:**Start: Click here to enter a date.End Click here to enter a date. |
| **Psychologist Name:**Click to Enter Text | **Degree:** Choose a Degree |
| **Psychologist’s Address:** | **NPI#:** Click to Enter Text |
| **Street:** Click to Enter Text | **Suite**: Click to Enter Text | **Phone:** Click to Enter Text |
| **City**: Click to Enter Text | **State**: Click to Enter Text | **Zip**: Click to Enter Text | **Fax:** Click to Enter Text |
| **Has a Diagnostic Interview (90791) Taken Place?** Choose a Response  | **Date of Diagnostic Interview:**Click here to enter a date. |
| **Referred by Child Welfare Services:** Choose a Response | **Court Ordered:**  Choose a Response  |
| **Professional Who Referred Client to Psychologist for Testing:** |
| Name: Click to Enter Text | Degree: Choose a Degree | Specialty: Click to Enter Text | Phone: Click to Enter Text |
| **Case Background:**(Include current level of care, specific behaviors and symptoms of concern and impact on current functioning, risk factors, assessment/testing history including dates and types of prior evaluation, co-existing medical, psychiatric, substance abuse conditions, etc.)Click to Enter Text |
| **Purpose of Testing:**(Specify referral questions, outstanding issues related to differential diagnosis, contributions to the clinical treatment plan.)Click to Enter Text |
| **Diagnostic Information:** |
| **Current ICD Diagnostic Code Number and DSM Diagnostic Label:**(If no diagnosis exists, write “None”)Click to Enter Text |
| **Rule-Out Diagnostic Code Numbers and Names to be Evaluated:** |
| **ICD Diagnostic Code Number:** Click to Enter Text | **DSM Diagnostic Label:** Click to Enter Text |
| **List All Tests Required:**(Please spell out names of tests. Indicate if administering select or supplementary subtests.)Click to Enter Text |
| **Applicable CPT Codes, Units or Hours Requested:** |
| 1. **Psychiatric Diagnostic Evaluation:** *(Not included in the 11 hours from D below)*

90791 (Maximum 1 unit): Choose a Response |
| **\*\*Please note the Psychological Testing Evaluation, Test Administration, and Scoring Hours may not collectively exceed 11 hours of service total.** |
| 1. **Psychological Testing Evaluation:**

96130 (first hour; maximum one unit): Choose a Response96131(each additional hour): Choose a Response | 1. Total number of hours requested in B & C: Choose a Response

**(***Cannot Exceed 11 Hours)* |
| 1. **Test Administration and Scoring**:

96136 (first 30 minutes; maximum one unit): Choose a Response96137 (each additional 30 minutes):Choose a Response |