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 Response  96131(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 Response  96137 (each additional 30 minutes):Choose a Response | | | | |