



REQUEST FOR AUTHORIZATION OF PSYCHOLOGICAL TESTING

- Instructions: In order to facilitate rapid processing of your treatment plan, please:**
- Type or print legibly to prevent the return of forms for clarification
 - The authorization must be obtained PRIOR to actual testing. This is service that must be precerted
 - Identify self-report inventories, checklists, etc. filled out by consumer, parent or clinician.
 - Evaluations for specific/primary purpose of diagnosing learning disabilities or intellectual functioning cannot be authorized. These evaluations should be pursued through the school system.
- You may fax your request to: **Gateway Health PlanSM Fax 717-540-1146**
 - **Call 1-866-755-7299 for questions regarding this form.**

Date of Request: _____

MEMBER INFORMATION:

First and Last Name: _____ Date of Birth: _____

Gateway Health PlanSM ID Number: _____ ID Number: _____

Other Insurance: _____ County of Residence: _____

PROVIDER INFORMATION:

Agency Requesting Service: _____ Contact Person: _____

Address: _____ Phone Number: _____

Date of testing (if scheduled): _____

CLINICAL INFORMATION:

Clinical Symptoms & Reason(s) for Referral:

Specific Questions that Cannot Be Answered Through Evaluation Processes:



Gateway Health PlanSM 1-866-755-7299 Fax: 717-540-1146

Psychological Testing: Member Name: _____ Gateway Health PlanSM #: _____

Treatment History:

Treatment & Provider: _____

Prior Testing or Evaluations, Including Dates:

Working Diagnosis and Rule Outs:

Psychological Tests to be administered	Time required for administration, scoring, interpretation and report preparation of each test

Psychological Testing: **Billing Codes:** 96101, 96102, 96103, 96118, 96119, 96120

Total number of hours requested for testing: _____
Billing code: _____

Requestor Signature: _____ **Date:** _____