

**DMHAS GA Behavioral Health Program**

Advanced Behavioral Health, Inc.

Phone: 800-606-3677 Fax: 860-704-6145

**REQUEST FORM**

**Request for Pre-Authorization of Neuropsychological or  
Psychological Testing**

Psychological testing is encouraged where it is clearly indicated and necessary for diagnostic or treatment planning purposes. Requests for testing will only be considered when normal clinical evaluation fails to resolve questions that directly impact on the choice of treatment modalities for covered conditions. **This report must be received and authorized by ABH prior to testing.** Return the completed form to:

***DMHAS GA Behavioral Health Program***

**c/o Advanced Behavioral Health**

**213 Court Street 10<sup>th</sup> floor**

**Middletown, CT 06457**

Patient's Name:

Date of Birth:

Patient's Social Security #:

Patient's EMS ID#:

Patient's Address:

Provider's Name/Discipline:

Provider's Address:

Provider's Tax ID #:

Phone #:

- 1. Who initiated this referral?**
- 2. What are the referral questions?**
- 3. Brief psychiatric and substance abuse history of patient (including any previous psychiatric or substance abuse admissions/treatment, and/or any previous psychological testing):**

**Patient Name:** \_\_\_\_\_

**4. Describe how the treatment plan is going to be affected by the results of testing:**

**5. Current diagnoses under evaluation (DSM-IV):**

Axis I: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_  
 Axis II: (1) \_\_\_\_\_ (2) \_\_\_\_\_  
 Axis III: \_\_\_\_\_  
 Axis IV: \_\_\_\_\_  
 Axis V: (HGAF): \_\_\_\_\_ (LGAF): \_\_\_\_\_ (Current): \_\_\_\_\_

**6. List the test(s) that most appropriately describe the question(s) to be answered:**

<i>Clinical Questions</i>	<b>Specific Test(s) Planned to Address this Question</b>	<i>Office Use Only</i>
a. Organic/neuropsychological factors related to disturbances in functioning		
b. Learning disabilities		
c. Disturbances in reality testing (psychosis)		
d. Degree of affective/behavioral disturbance manifested		
e. Nature of personality structure		
f. Intellectual functioning		

How many units (hours) are you requesting authorization for? \_\_\_\_\_

Name of Psychologist performing testing: \_\_\_\_\_  
 (Please Print)

Connecticut License Number: \_\_\_\_\_

\_\_\_\_\_  
 (Signature of Psychologist)

\_\_\_\_\_  
 (Date)