The Holman Group
Managed Behavioral Health Care Services

Request for Psychological Testing Authorization

PATIENT/ INSURER'S INFORMATION			
Patient Name:		**Insured:**	
Date of Birth:		**Insured ID:**	
Age:		**Employer/ Union:**	
Patient Ph#:		**Relationship:**	
PROVIDER/ FACILITY INFORMATION			
Provider/ Facility:		**Phone#:**	
Address:			

AUTHORIZATION REQUEST INFORMATION	
Has the Patient been tested in the last twelve (12) months?	☐Yes ☐No
What questions are to be answered by the psychological testing?	
List the name of all tests to be performed (Add additional page if more space is needed):	

CPT Code	# of Units Requested	Dates of Service

Results/ Symptoms of the initial diagnostic interview?
What previous treatment has the member/ patient received?
How will the results of the testing be used to guide treatment decisions?
Can the above information be answered by other means (i.e. clinical assessment, medical or neurological consult review of psychological/psychiatric records)?

PROVIDER/ FACILITY SIGNATORY

I certify that the above is true and correct. The treatment plan has been reviewed and agreed upon by the patient.

Provider Name/ Title (Print)	**Signature**	**Date**