Vaya Health

Psychological Testing Authorization Request Form

Request date: _____

MEMBER INFORMATION

Member's first and last name: _____ **Date of birth:** _____

MID: _____ **LME/MCO record number:** _____

ENTITY MAKING REQUEST FOR TESTING

☐ Member ☐ Psychotherapist ☐ Court ☐ Other: _____
☐ Family ☐ Psychiatrist ☐ DSS
☐ Medical provider ☐ School/educator ☐ Vaya Health

EVALUATING PSYCHOLOGIST OR PSYCHOLOGICAL ASSOCIATE

Name and credentials: _____ **Practice name:** _____

Telephone: _____ **Mailing address:** _____

PRIOR ASSESSMENT INFORMATION

Date of most recent Comprehensive Clinical Assessment: _____ **Appended?** ☐ Yes ☐ No

Conducted by: _____

Summary of findings/recommendations: _____

Date of most recent psychiatric evaluation: _____ **Psychiatrist:** _____

Summary of findings/recommendations: _____

Has there been prior psychological testing? ☐ Yes ☐ No

If yes, provide date: _____ **Individual who conducted testing:** _____

Current diagnosis(es): _____

Leveling tool scores: LOCUS: _____ CALOCUS: _____ ASAM: _____ NC-SNAP: _____ SIS: _____

REASONS FOR TESTING

What clinical questions will be answered by the proposed testing?

_____

Why can this information not be obtained through a diagnostic interview?

_____

How will testing results support or enhance the member's treatment?

_____

REQUESTED TESTING

Test	Purpose	Requested time	CPT code
	Total requested time:		

SUBMISSION INSTRUCTIONS

Refer to Vaya Health's Psychological Testing Guidelines on the Vaya website, www.vayahealth.com, for information about psychological testing requirements.

Contracted providers:

Complete this form and submit with the SAR by uploading to AlphaMCS.

Non-network providers:

Complete this form and send via FAX to Vaya at 1-877-260-6517.