of Tennessee

Psychological Testing Form

Please check line of business for this form:

- ☐ BlueAdvantage (PPO)SM
- ☐ BlueCare Plus (HMO SNP)SM
- ☐ CoverKids
- ☐ BlueCareSM
- ☐ TennCare *Select*

Member number: _____

Member name: _____

Member date of birth: _____

Member contact number: _____

Date request sent: _____

Case type: psychological testing

Provider name: _____

Provider phone: _____

Provider fax: _____

Place of service: office

Requesting clinician:

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address:

Treating clinician (list credentials): _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address:

Requested facility: _____

Facility provider ID #: _____

Facility NPI #: _____

Facility address:

Psychiatric ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Medical ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Requested start date of service:_____

(Note: If start date is prior to the request received date, it must be requested as a retrospective review and may be denied for non-compliance.)

Number of hours requesting: _____

Clinical Information Section

(For initial review. Please see other applicable sections below and fill out all that apply.)

Who initiated referral for psychological testing? _____

Why is testing being requested at this time?

Describe how proposed testing will clarify diagnosis and impact future behavioral treatment:

Describe in detail the patient's current condition to include… (thorough mental status, behavioral symptoms):

Treatment history:

Prior testing and date of last testing
(psychological, medical, psychiatric and neurological exams with results):

Medications	Dose	Frequency	Dates	Outcome

Medication adherence? Barriers to adherence?

Substance abuse concerns?

If repeat testing is being requested, why is it needed at this time?

Specific psychological tests being requested
(full name of test written out) with specified time for each one:

Test Name	Test Time

Total hours being requested: _____

Signature of ordering clinician with credentials
(required in order to process): _____

Date of signature: _____

Fax pre-certification numbers:

BlueAdvantage: 1-888-535-5243

BlueCare Plus: 1-866-325-6698

Bluecare/TennCare*Select*: 1-800-292-5311

CoverKids: 1-800-851-2491

Customer service numbers:

BlueAdvantage: 1-800-841-7434

BlueCare Plus: 1-800-299-1407

BlueCare: 1-800-468-9736

TennCare*Select*: 1-800-276-1978

CoverKids: 1-800-924-7141

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Behavioral Health Fax Form-
Psychological