

BEHAVIORAL HEALTH SYSTEMS
Psychological Testing Authorization Request Form

Patient Information:

Name: _____ Insured's ID Number: _____
Insured's Employer: _____

Provider Information:

Testing Provider's Name: _____ Phone: () _____
Office Contact Person: _____ Fax: () _____

Referral Source: _____

Prior Psychological Testing:

Date: ____/____/____ No ____

Psychiatric Evaluation:

Date: ____/____/____ No ____

Have you completed a comprehensive Initial Assessment Yes ____ No ____

DSM-IV-TR Diagnosis:

Axis I _____
Axis II _____

Other diagnoses under consideration:

Specify all diagnostic and/or clinical questions to be answered:

List specific tests proposed and time required for each:

Tests (do not use abbreviations)	Time
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Total Time Requested: _____

Physician Signature

Date

Please fax completed form to BHS Clinical Services at (205) 879-1178