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## REQUEST FOR PSYCHOLOGICAL TESTING AUTHORIZATION

Date of Request \_\_\_\_\_ Consumer Name \_\_\_\_\_  
Medicaid # \_\_\_\_\_ Consumer DOB \_\_\_\_\_  
Medicare # \_\_\_\_\_ or N/A  
Name of Provider Requesting Testing \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
Agency/Provider to Complete Testing \_\_\_\_\_  
License # of Testing Psychologist \_\_\_\_\_ Fax # \_\_\_\_\_

**This is a request for Psychological Testing. Please answer the following questions and fax to the above cited fax number.**

1. Describe the symptoms the patient is exhibiting and explain why you are requesting psychological testing.
  
  
  
  
  
  
  
  
  
  
2. What is the differential diagnosis?
  
  
  
  
  
  
  
  
  
  
3. What is it about this case that makes it difficult to make a diagnosis based on the clinical presentation?

4. What questions would you like answered by the psychological testing?

5. Have other consultations been obtained (i.e. PCP, psychiatrist, neurologist)? If so, please include their findings.

6. What medications have been tried (include the dosage and length of use, and how effective each trial was):

Medication	Dosage	Period of Use	Effectiveness

7. How will the results of the psychological testing change your therapeutic approach?

**Please attach a copy of your clinical assessment and results of previous testing.**