INDEPENDENT CARE HEALTH PLAN

Neuro-Psychological & Psychological Testing Clinical information Guidelines

This is a guideline only. Please include all of the following information with the prior authorization request to avoid any delay in processing.

Member Name: _____ DOB: _____

Psychologist to perform the Testing: _____

Referral Source: (provider who referred Mbr for testing)

Name: _____ Specialty Type: _____

***Please Fax Form to (414)231-1026**

Case Background:

(Include Member specific behaviors and symptoms of concern, assessment/testing history with dates and types of prior evaluation, co-existing medical, psychiatric and substance abuse conditions etc.).

Purpose of Testing:

(Specify referral questions, issues related to differential diagnosis, contributions to the treatment plan)

Please list the possible tests requested (i.e. MMPI-2, Millon Inventories, WAIS, etc.)

Updated 04/2016

INDEPENDENT CARE HEALTH PLAN
1555 N. RiverCenter Dr. Suite 206
Milwaukee, WI 53212
Tel 414-223-4847 Fax 414-231-1092
www.icare-wi.org