Community HealthFirst™
Medicare Advantage Plans
Fax: 206-652-7067
Phone: 1-800-942-0247

Psychological Testing Request

Identifying Information:

Date _____

Subscriber ID _____ Member DOB _____

Member Name _____ Member Phone _____

Clinical Information:

Diagnosis: Axis I_____ II_____ III_____ IV_____ V_____

What Specific Questions Will Be Answered by the Evaluation?

1.

2.

3.

Describe how the evaluation will help to implement the treatment plan

Describe what other strategies have failed to implement the treatment plan

Has the patient had previous testing?_____If yes, when?____/___/___

What were the results of the testing?

Specify the Proposed Measures and Rationale for their Use:

1. Measure Name_____CPT_____Hours _____

   Rationale:

2. Measure Name_____CPT_____Hours _____

   Rationale:

3. Measure Name_____CPT_____Hours _____

   Rationale:

4. Measure Name_____CPT_____Hours _____

   Rationale:

5. Measure Name_____CPT_____Hours _____

   Rationale:

Provider Information:

Name_____ Licensure _____

Phone_____Fax_____Tax ID _____

Address_____

Provider, please indicate if you have consulted with the patient's PCP regarding the member's treatment plan or progress:

- ☐ Treatment reviewed with PCP.
- ☐ PCP not contacted.

I certify that I am the provider who will be delivering the services listed above and that the information contained herein is true and correct to the best of my knowledge.

_____ _____

Provider Signature Date

Please fax completed form to Community Health Plan of Washington at 206-652-7067.