Connecticut BHP
Supporting Health and Recovery

PSYCHOLOGICAL TESTING TEMPLATE

Retroactive Eligibility Template ☐ **Yes** ☐ **No**

If yes, PLEASE COMPLETE AND FAX TO 1(866) 434-7681

Provider EDS/CMAP ID # (Medicaid 9-digit ID): _____

Facility/Provider Name**:** _____ Contact # & Ext: _____

Facility/Provider Service Location: _____

Name of clinician who filled out this form: _____ Credentials/Title**:** _____

Member Name: _____

Medicaid/Consumer ID#: _____ DOB**:** _____ and/or SSN: _____

QUESTIONS: *(* signifies a required field)*

1. *** PhD Contact Name:** _____ *Phone: _____
2. *** Are you independently licensed?** ☐ Yes ☐ No
3. *** Current Symptoms and duration of symptoms?**

_____

_____

_____

4. *** What are the referral questions and why is testing being requested at this time?**

_____

_____

_____

5. **Behavioral Diagnoses (*Primary is required)***

***Diagnosis Code:** _____ **Description**_____

***Diagnostic Category:** _____

Diagnosis Code: _____ **Description**_____

Diagnostic Category: _____

6. *** History of Patient** (Summary of psychosocial and medical information and past treatment: Include any past psychological testing, date and results, medical, psychiatric and neurological exams):

_____

_____

_____

7. *** Describe how proposed testing will enhance treatment and impact future behavioral treatment:**

_____

_____

_____

8. *** Is patient currently in treatment?** ☐ Yes ☐ No

a) **If yes, specific modality (i.e. individual, group, family, etc.):**

_____

_____

9. *** Are there clinical explanations, other than psychological ones that could explain current behaviors/symptoms (i.e. thyroid dysfunction, closed head injury, medications, poisoning, etc.)?** ☐ Yes ☐ No

a) **If yes, please explain:**

_____

_____

10. *** List test(s) planned and time required for each test (i.e. Rorschach = 2 hours, Thematic Apperception Test = 1 hour):**

Specific Test(s) Planned:	Hours Required for Specific Test: