Humana
Healthy Horizons™ in South Carolina

Healthy Connections

Psychological and Neuropsychological Testing

Please complete form in its entirety and return to:
Email: CorporateMedicaidCIT@humana.com
Fax: **833-441-0950**

Behavioral Health Authorization Request Form

Service request start date:	Is this a post service request? ☐ Yes ☐ No

Member Information

Last Name		First Name	Date of Birth
Phone Number		Humana ID#	Gender ☐ Male ☐ Female
Third-Party Insurance	☐ Yes ☐ No	If Yes, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.	Languages Spoken

Treating Provider/Practitioner Information

Last Name	First Name	NPI
Humana ID#	Participating ☐ Yes ☐ No	Discipline/Specialty
Street Address	City, State	Zip
Phone Number	Fax Number	Office Contact

Facility/Agency Information

Name	Facility ID	NPI
Street Address	City, State	Zip
Phone Number	Fax Number	Office Contact

Diagnosis - Code and description

Service Type Requested	List CPT Code(s)	List the Specific Tests/Scales	Units / Hours Requested per Test
Psychological Testing			
Neuropsychological Testing			

Total number of hours requested for all tests:

Disclaimer: An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

Psychological and Neuropsychological Testing Behavioral Health Authorization Request Form

Diagnosis - Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Problems	
Are services requested court ordered? ☐ **Yes** ☐ **No** If **yes**, please submit a copy of the court order and all supporting documentation.	

Symptoms/Functional Impairments of concern	
What are the symptoms/functional impairments of concern? Attach additional notes or a copy of diagnostic interview if needed.	

Testing Results Action** Required	
How will the testing results impact the decision regarding treatment options?	

Rationale for Request	
Testing referral source:	
☐ Court/DJJ**	☐ Psychologist
☐ Parent	☐ School
☐ PCP	☐ State Agency
☐ Psychiatrist	☐ Other (Please specify)
What is the overall clinical question that needs to be answered by the requested testing?	
Has the member had an evaluation by a psychiatrist? If so, by whom and when? If not, why not?	
Has the member had a diagnostic interview? If **yes**, date of interview? Name and credentials of provider who completed the interview?	
Why can't the questions at hand be answered by the diagnostic interview, a review of the member's record, or a second opinion instead of testing?	
Has the member had testing before? If so, by whom and when?	

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Previous Treatment			
Type	Frequency	Duration	Provider (if know)

Current Medication (Psychotropic and medical)			
Type	Frequency	Duration	Adherent?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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