

DATE OF 1st CALL:

INITIALS
FILLING OUT
FORM:



"An Individuals First Choice"
 4701 Fayetteville Road Lumberton, NC 28358 2697
 Phone (910) 738-3939 – Fax (910) 738-9799
www.primaryhealthchoice.org

Referral Form for Psychological Testing

Client Information

Name:	Date of Birth:	Race/Ethnicity:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	School & Grade:	
Services Requested: <input type="checkbox"/> Psychological Testing		
CONTACT NUMBERS:	Message ok? <input type="checkbox"/> Yes <input type="checkbox"/> No	
ADDRESS:		

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	Address:
Contact Numbers:	Type of setting: <input type="checkbox"/> Home <input type="checkbox"/> Group Home <input type="checkbox"/> Foster Home <input type="checkbox"/> Psychiatric hospital <input type="checkbox"/> Other

Payment Information:

Type of Insurance: Medicaid <input type="checkbox"/> UHC <input type="checkbox"/> Alliance <input type="checkbox"/> BCBS <input type="checkbox"/> Humana <input type="checkbox"/> Other (please note, these are OON and self-pay)
<input type="checkbox"/> Trillium <input type="checkbox"/> United Healthcare Com. <input type="checkbox"/> Medicare <input type="checkbox"/> Vaya Health <input type="checkbox"/> MedCost <input type="checkbox"/> UHC Optum Behavioral Health <input type="checkbox"/> Aetna
<input type="checkbox"/> Carolina Complete <input type="checkbox"/> Healthy Blue <input type="checkbox"/> Community Plan
<input type="checkbox"/> Well Care <input type="checkbox"/> Partners <input type="checkbox"/> Ameri Health
Primary Insurance ID# _____ Phone # _____
Secondary Insurance ID# _____ Phone # _____

Insured Person (if not patient)

Name:	Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
CONTACT NUMBERS:	

ADDRESS:

Referral Source Information: Complete this section so we can contact you after the referral is made.

Name	Mailing Address
Phone#	Fax#
Email address:	
How did you hear about Primary Health Choice Psychological Testing Services?	

What is the clinical question to be answered by testing?

What is the reason this question cannot be answered by a diagnostic interview, medical/neurological consult, review of psychological/psychiatric records or second opinion?

**What are the current symptoms and/or functional impairments related to testing question?
Describe the member's current presentation.**

How would the results of testing affect the treatment plan? Be specific.

Has the member used any substances in the last 30 days?

Yes No

If yes, describe:

Has the testing psychologist or other behavioral health professional completed an initial diagnostic evaluation (which can include school psychoeducational testing) ?

If yes, please fax records or have patient upload into the client portal once given access

Yes – Date of evaluation:

No

Has the patient been evaluated by a psychiatrist?

Yes – Date of evaluation:

No

Has there been previous psychological testing?

Yes – Date of evaluation: _____

No _____

Testing area of focus:

If yes, please fax report or have patient upload into the client portal once given access

Child/Adult Mental Health Information:

Current medication & dosage	Current DSM-IV Diagnosis

Prescribing Physician name & Phone

Current Mental Health Symptoms:	Unknown	Not Present	Mild	Moderate	Severe
Hallucinations (describe)					
Delusions					
Thought disorder					
Bizarre (psychotic) behavior (describe below)					
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

CPT codes and descriptions For services rendered on or after Jan. 1, 2019	Requested units
96130 – Psychological testing evaluation services by physician or other QHP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s); when performed, first hour	_____ unit (only 1 unit of 1 hour allowed)
96131 – Psychological testing evaluation services by physician or other QHP; each additional hour	_____ number of additional hours
96132 – Neuropsychological testing evaluation services by physician or other QHP, integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s); when performed, first hour	_____ unit (only 1 unit of 1 hour allowed)
96133 – Neuropsychological testing evaluation services by physician or other QHP; each additional hour	_____ number of additional hours
96136 – Psychological or neuropsychological test administration and scoring by physician or other QHP; 2 or more tests, any method, first 30 minutes	_____ unit (only 1 unit of 30 minutes allowed)
96137 – Psychological or neuropsychological test administration; 2 or more tests, any method, each additional 30 minutes	_____ unit(s) additional units of 30 minutes each
96138 – Psychological or neuropsychological test administration and scoring by technician; 2 or more tests, any method, first 30 minutes	_____ unit (only 1 unit of 30 minutes allowed)
96139 – Psychological or neuropsychological test administration and scoring by technician; 2 or more tests, any method, each additional 30 minutes	_____ unit(s) additional units of 30 minutes each
96146 – Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	_____ unit (only 1 unit of 1 hour allowed)
Total number of hours requested (count automated test administration as 1 hour):	_____ total hours (use .5 to indicate half an hour [e.g., 5.5])

Testing provider information:

Primary Health Choice, Inc.
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www.primaryhealthchoice.org