AlohaCare
For a healthy Hawaii.

# OUTPATIENT PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING REQUEST

*Type of request:*
- Expedited
- Standard
- Retrospective

| | |
|---|---|
| **Referring Provider Name:** (Primary BH Provider) | **Phone:** |

**REQUESTED PROVIDER INFORMATION**

| | |
|---|---|
| **Requested Provider Name:** | **Specialty** ☐ MD ☐ DO ☐ PhD/PsyD ☐ LCSW ☐ CSAC ☐ LMHC/LMFT ☐ APRN/NP |
| **If affiliated with a Clinic/Facility, Please Indicate Facility Name:** | Office Contact Person: |
| **Phone:** | **Fax:** |

**MEMBER INFORMATION**

| | | |
|---|---|---|
| **Member Name:** | **Member ID:** | **DOB:** |

**REASON FOR REQUEST**

**A. TYPE OF TESTING REQUESTED (please select):** ☐ Psychological ☐ Neuropsychological

(**NOTE**: Must provide documentation of acute brain insult or other Neuropsychological conditions & Psych test history to support Neuropsychological testing)

**B. Please provide supporting history & reason for testing:** ____________________

**C. Please indicate goal for testing:** ____________________

**D. How will testing benefit the patient & provider:** ____________________

**E. TESTS** - Please list the recommended tests for this patient: ____________________

Requested # of contact hours for psychological testing: ________ # of Visits: ________ Begin: ________ End: ________

Requested # of contact hours for neuropsychological testing: ________ # of Visits: ________ Begin: ________ End: ________

Who will administer the tests (notate name/title): ____________________

Notes/Comments:
(If Applicable)

**Provider Signature:** **Date:** ________

FOR ALOHACARE USE ONLY: PROGRAM: ☐ QI ☐ ACAP AUTHORIZATION #: ____________________

Auth Svc: ____________________

Approve Date: ____________________ Denied Date: ____________________

Denial Reason: ____________________ Init/Date: ____________________



**ALOHACARE**
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To contact the BH Dept., call 973-1650 (Oahu) or 1-800-434-1002 (NI)
FAX: 973-6324 or 1-800-293-4580