Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Psychological Testing

Upload this request through the Provider Web Portal. Questions? Call: (800) 525-2395

DATE OF REQUEST: ______ /______ /________

Incomplete or illegible forms cannot be processed.		
RECIPIENT INFORMATION		
Recipient Name (Last, First, MI):		
Recipient ID:		DOB:
Responsible Party Name:		
REFERRING PROVIDER INFORMATION		
Referring Provider Name:		NPI:
Phone:	Fax:	
PSYCHOLOGIST INFORMATION		
Psychologist Name:		NPI:
Phone:	Fax:	
CLINICAL INFORMATION		
Date of Testing:		
Requested Testing *(enter the number of units for each code requested)*: ____96130 ____96131 ____96136 ____96137 ____96138 ____96139		
Has previous testing been performed? ☐ No ☐ Yes: If yes, enter date and results: ____/____/_____ Results:		
Is this request for Healthy Kids (EPSDT) services? ☐ No ☐ Yes		
Current diagnosis/diagnoses under evaluation:		
Current symptoms:		
Relevant history:		
Medications:		

Psychological Testing

Which of the following has been completed?:

____Diagnostic Interview (Date completed:_______________)

____Review of records

____Brief inventories and/or rating scales

____Medical/Primary care exam

____Psychiatric evaluation

What is the specific referral question that testing is intended to answer?:

What diagnosis/diagnoses will testing rule out?:

How will the test results impact treatment?:

Requested Tests *(No abbreviations)*	**Requested Tests** *(No abbreviations)*
1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Requesting Provider Signature:	**Date:**

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