Hennepin Health
Minneapolis Grain Exchange Building
400 South Fourth Street, Suite 201
Minneapolis, MN 55415

PrintForm

PSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

Phone: 612-596-1036 Fax: 612-677-622

Complete this form if client/patient will receive over 8 hours of testing within a calendar year.
For codes: 96101, 96102, and 96103

Member Name:

Member ID#:

Member Date of Birth:

Provider Name:

Provider Degree/Lic.

Clinic Name:

Is this treatment court ordered? If yes, submit court order and evaluation. ◯ Yes ◯ No

Provider Phone#

Provider Fax#

Referred by: ◯ PCP ◯ Family ◯ County ◯ School ◯ Mental Health Provider Other:

Please explain why additional hours of testing are required (over the 8 hours per calendar year)

Tests client/patient has completed: ◯ Beck Depression Inventory ◯ Connors or Achenbach ◯ Mini Mental Status

Others:

List Medications Prescribed ◯ Anti-Anxiety Agents ◯ Antimanic Agents ◯ Anticonvulsants ◯ Antidepressants ◯ Sedatives/Hypnotics ◯ Antiparkinson's ◯ Antipsychotics

◯ Stimulants Other:

Current Substance Abuse?: ◯ Yes ◯ No

If Yes, please elaborate:

Additional Tests Requested - include codes

Provider Signature/Date _____

Provider Signature/Date _____

MH Form 8/2016