

**NEW DIRECTIONS BEHAVIORAL HEALTH
REQUEST PSYCHOLOGICAL TESTING FORM FOR BCBS OF KANSAS**

Provider Info:

Name: _____ NPI# _____

Address: _____ Phone#: _____

Client Info:

Name: _____ Insured ID#: _____ DOB: _____

Axis I: _____ Axis II: _____ Axis III: _____

Axis IV: _____ GAF: Current _____ Past Year _____

Has the member had a psychiatric medication evaluation? Yes No planned unknown

Current medications and dosage: _____

Describe HX of psychiatric tx: _____

Dates and names of prior testing: _____

Referral source: _____

Testing instruments to be used: _____

Hours of testing needed and start date: _____

96101- 96102- 96103- 96116 96118- 96119- 96120-

Plan for giving feedback re: test results: _____

Diagnostic question to be answered with testing

Provider Signature

Date

Please FAX this request to: 913-982-8176

or Mail to: NDBH, PO Box 1627, Topeka, KS 66601-1627

For questions, please call: (800) 952-5906