



Molina Healthcare of Texas, Inc.

Psychological / Neuropsychological Testing Request (Outpatient)

Please submit this form for any testing requests for more than 8 hours of service or if the request comes after 30 other outpatient service encounters within a benefit year.

Member: _____ DOB: _____ Age: _____
 Molina #: _____ Parent name (if child member): _____
 DSM-IV Diagnosis: _____
 Referral Source (identify by name and function): _____

Referral Question: _____
 Relevant History: _____

Past Assessment & Service Summary (testing, school evaluation / IEP / Early Intervention, ADHD dx/tx, behavior ratings, etc.): _____

Tests Requested (may substitute with attached list):

Hours Requested (enter in applicable box/boxes below):

Hours	CPT/Service	Hours	CPT/Service
	96101 Psychological Testing by Psychologist		96118 Neuropsychological Testing by Neuropsychologist

Provider Name & Degree: _____ **License #:** _____
Supervisor Name (if provider is unlicensed): _____ **License #:** _____
TIN or SSN: _____ **Agency or Facility:** _____
Address: _____
Phone: _____ **Fax:** _____

Fax to: 1-866-617-4967 Questions: Call the Behavioral Health Hotline @ 1-800-818-5837