

Anthem UM Services, Inc.  
370 Bassett Road.  
Bldg. 3, Floor #2  
New Haven, CT 06410  
Fax: 203-654-3307  
or 203-654-3306

## Request for Psychological Testing

### Patient Information (must be completed):

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID #: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

### Provider Information:

Provider Requesting Testing: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Provider/Facility Identification Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

Provider to Administer Testing: \_\_\_\_\_

Provider/Facility Tax Identification Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

### Clinical Information:

Current Diagnosis (DSM IV) : Axis I \_\_\_\_\_ Description \_\_\_\_\_

Axis II \_\_\_\_\_ Description \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV \_\_\_\_\_

Current GAF \_\_\_\_\_ Highest Past Year \_\_\_\_\_

Has patient recently been in treatment? \_\_\_\_\_ How long and with whom? \_\_\_\_\_

Current psychotropic medications: \_\_\_\_\_

Previous psychotropic medications: \_\_\_\_\_

(Please proceed to next page)

**Request for Psychological Testing continued...**

What current symptoms or conditions suggest the need for testing? \_\_\_\_\_

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Has the patient had any previous testing? (If so, please include dates, tests administered and results) \_\_\_\_\_

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Specific questions to be answered by testing: \_\_\_\_\_

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Please describe how the testing is necessary for diagnosing and treating the patient: \_\_\_\_\_

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**Test Proposed:**

Name of Test	Purpose	Time Needed
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Projected Date of Testing: \_\_\_\_\_

Signature of Provider (completing form): \_\_\_\_\_ Date: \_\_\_\_\_

Address/Phone/Fax (if different from providers on front): \_\_\_\_\_

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