COMMUNITY FIRST
HEALTH PLANS

Psychological Testing Request Form

Please complete this form to request psychological testing for a Community First Health Plans Member.

Member Name: _____ **Date of Request:** _____

Member DOB: _____ (MM/DD/YYYY) **Member ID Number:** _____

Diagnosis: _____

Requested By/Attending MD: _____

Has previous testing been completed? Yes ☐ No ☐ If yes, date tested: _____

Psychologist referring to: _____

Please list tests: _____

_____

_____

Please list the reason(s) why psychological testing is being requested: _____

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Please fax this completed form to 210-358-6387.

If request for psychological testing is authorized, an authorization number will be faxed to the requesting Provider.

12238 Silicon Drive, Ste. 100
San Antonio, TX 78249
F: (210) 358-6387 | PH: (210) 227-2347