



Date of Form Submission:

Notification Review for Psychological Testing Service

Please print clearly. Incomplete or illegible forms can not be processed.

Client Information

Client's Name	Client's Date of Birth	Client's Phone #
Client's Insurance Group #	Client's Insurance ID #	Client's Address
Policy Holder's Name	Client's Presenting Issue	Authorizations are usually completed within 1-3 business days.

Provider Information

Services requested (Please include number needed): 90801: _____ 96101: _____ 96102: _____ 96103: _____ 90887: _____ Other: _____

List Tests To Be Administered	Minutes*
Total Time Requested:	

Name of Clinician Performing Tests Credentials

Name of Clinic/Organization Phone #

Requestor's Name Email & Fax #

*Minutes should include total time for administration, scoring & interpretation

Submit completed forms via email or fax to TEAM

TEAM Corporation
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