Date of Form Submission:

Authorization Request 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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