COMMUNITY FIRST
HEALTH PLANS

PSYCHOLOGICAL TESTING REQUEST FORM

Member Name _____ Date of Request _____

Member Date of Birth _____ Member ID Number _____

Diagnosis _____ Requested By/Attending MD _____

Previous Testing YES O NO O _____ Date Tested _____ Psychologist Referring To

If yes, list tests: _____

Reason Psychological Testing is being requested:

If request for psychological testing is authorized and authorization number will be faxed to the provider.