Insight
COUNSELING AND TESTING SERVICES

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Psychological Testing Referral Form

Psychological Testing and Evaluations for Children, Adolescents and Adults

Date: _____

Patient Name: _____ DOB: _____ Phone #: _____

Mailing Address: _____ Email Address: _____

Insurance Company: _____ Contract Number: _____

Referring Clinician: _____

Office Phone #: _____ Fax #: _____

Please list referral questions/reasons for referral:

When Completed by Clinician, Please Fax to 256-510-5410
Thank You for your Referral

(For Office Use Only)

Appointments needed: ☐ 1 two-hour ☐ 2 two-hour ☐ 1 one-hour AND 1 two-hour

Effective dates: _____-_____ Covers _____% of allowed amount. Copay / Coinsurance: _____

Deductible applies? Yes / No Individual: _____ met of _____ Family: _____ met of _____

OOP applies? Yes / No Individual: _____ met of _____ Family: _____ met of _____

Referral required? Yes / No Preauthorization required? Yes / No

Exclusions: _____

Insurance Guarantor Name: _____ D.O.B. _____

Insurance Rep Name: _____ Call Ref. #: _____

Spreadsheet: ☐