Request for Authorization: Neuropsychological Testing

Please submit this form electronically using our preferred method at https://www.availity.com. This can also be submitted via fax to 1-877-434-7578.

General information

Member information					
Member name		Date of birth		Member ID	
Provider information					
Name of psychologist		Provider ID		Phone	
				Fax	
Address		Provider NPI		Provider email	
Referral information					
Name of referral source		Specialty		Address	
Phone					

Neuropsychological testing, also known as psychometric testing, is a comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders. This testing may be used to augment a comprehensive medical history and physical examination as well as neurological investigation of certain conditions.

Neuropsychological testing is considered medically necessary when there is evidence to suggest that the test results will have a timely and direct impact on the member's treatment plan for certain indications. Repeat testing to track the status of an illness or recovery progress is subject to individual case consideration but is generally not warranted.

Clinical information (Please include any relevant medical records to support the request for testing.)

☐ Traumatic brain injury, date:	☐ Encephalitis, date:	☐ Epilepsy and cognitive impairment suspected or documented, date:	☐ Multiple sclerosis and suspected or demonstrated cognitive impairment, date:

☐ Anoxic/hypoxic brain injury, date:	☐ CVA, date:	☐ Psychosis, date:	☐ Major affective disorder, date:
☐ History of intracranial surgery, date:	☐ Brain tumor in remission or with slow progression, date:	☐ Neurosurgery planned for epilepsy control, date:	☐ Head injury with loss of consciousness, date:
☐ Confirmed neurotoxin exposure, date:	☐ Dementia suspected, date:	☐ Other, date:	☐ Other, date:

Clinical assessment

□ Clinical interview with patient, date:	□ Psychiatric evaluation, date:	□ Structured developmental/ psychosocial history, date:	□ EEG, date:
□ Neurologic exam, date:	□ Neurobehavioral exam, date:	□ Consultation with school or other important persons, date:	□ Medical evaluation, date:
□ Consultation with PCP, date:	□ Brief rating scales or inventories, date:	□ Neuroimaging (CT, MRI, PET), date:	□ Interview with family member(s), date:

Date of clinical interview:

Enter other pertinent history or clinical information relevant to this request for neuropsychological testing.
Has the patient had previous psychological/neuropsychological testing? ☐ Yes ☐ No If yes, date of testing: What were the reasons for testing and the results?
List the medication(s) the patient is taking or mark the box if none. ☐ None

Have medication effects been ruled out as a cause of cognitive impairment? ☐ Yes ☐ No Have alcohol and/or illicit substance effects been ruled out as a cause of cognitive impairment? ☐ Yes ☐ No
Enter the patient's substance abuse history to date or mark the box if none. ☐ None
What are the specific questions to be answered by neuropsychological testing that cannot be determined from the above services? How will the test results impact this patient's treatment?
Enter ICD-10 diagnoses under evaluation.

Neuropsychological tests requested

Please list the tests you are requesting and expected administration time. For tests with multiple versions, specify which one. If you are administering selected subtests, please indicate which ones. Please attach a separate sheet if necessary. Total time requested in hours:

Provider signature: _____ Date: _____

For Amerigroup use only:

Date received: _____ Auth from: _____ 96116 _____hrs 96119 _____hrs Reference #: _____ Auth to: _____ 96118 _____hrs Other:

Authorization for routine outpatient care is not required for network providers treating eligible members. Authorization for neuropsychological testing is subject to verification of member eligibility and is not a guarantee of payment.

Note: We are unable to process illegible or incomplete requests.

Protected Health Information (PHI)
These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at 1-866-805-4589.

Providers: You are required to return, destroy or further protect any PHI you receive pertaining to patients that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

☐ By checking this box, I hereby certify that the protected health information (PHI) contained in the correspondence received in error has been destroyed and has not otherwise been retained, utilized, or further disclosed. In the event the PHI must be retained it will further be protected until the time it can be destroyed.