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MEDICARE
https://providers.amerigroup.com

Request for Authorization: Neuropsychological Testing

Please submit this form electronically using our preferred method at https://providers.amerigroup.com/NJ. You may also submit via fax to 1-800-505-1193.

General information

Member name:	DOB:	Age:	Member ID:
Name of psychologist:	Provider number:	Phone:	Fax:
Address:		Provider NPI:	Provider email:
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. For more information, see the *Clinical Utilization Management Guidelines* at https://medicalpolicies.amerigroup.com/medicalpolicies/guidelines/gl_pw_a053761.htm.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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 results and reasons for testing?

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 Community Care use only:

Date received:	Auth from:	96116 _____ hours	96119 _____ hours
Reference #:	Auth to:	96118 _____ hours	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.