

# Psychological & Neuropsychological Testing Request

Fax: 1-844-602-4630  
Phone: 1-866-816-1722

## IDENTIFYING INFORMATION

Date:	Subscriber ID:
Member DOB:	Member Name:
Member Phone:	

## CLINICAL INFORMATION

Level of Care (please check one):     Inpatient     PHP     IOP     Outpatient

Diagnosis: Axis I (DSM-5 or ICD-10)

Psychosocial Stressors:

What Specific Questions Will Be Answered by the Evaluation?

- 1.
- 2.
- 3.

Describe how the evaluation will help to implement the treatment plan:

Describe what other strategies have failed to implement the treatment plan

Has the patient had previous testing? \_\_\_\_\_ If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_\_

What were the results of the testing?

**SPECIFY THE PROPOSED MEASURES AND RATIONALE FOR THEIR USE:**

1. Measure Name:	CPT Code:	Hours:
Rationale:		
2. Measure Name:	CPT Code:	Hours:
Rationale:		
3. Measure Name:	CPT Code:	Hours:
Rationale:		
4. Measure Name:	CPT Code:	Hours:
Rationale:		
5. Measure Name:	CPT Code:	Hours:
Rationale:		

**PROVIDER INFORMATION**

Name:	Licensure (MD, PhD, PsyD):	
Phone:	Fax:	Tax ID:
Address:		

Provider, please indicate if you have consulted with the patient's PCP regarding the member's treatment plan or progress:

- Treatment reviewed with PCP.
- PCP not contacted.

I certify that I am the provider who will be delivering the services listed above and that the information contained herein is true and correct to the best of my knowledge.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

**Please fax completed form to: 1-844-602-4630**