PASSPORT ADVANTAGE (HMO SNP)

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