

SUBMIT TO  
**Utilization Management Department**  
Phone: 1.888.713.6180 Fax: 1.877.725.7751



FROM



## NEUROPSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Health Plan # \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name \_\_\_\_\_

Group Name \_\_\_\_\_

Provider Tax ID# \_\_\_\_\_ NPI# \_\_\_\_\_

Fax# \_\_\_\_\_ Phone# \_\_\_\_\_

### MEDICAL INFORMATION

History of medical condition, trauma or substance use disorder that may have neuropsychological consequences to the patient:

Patient's cognitive symptoms/issues:

Patient's psychiatric symptoms/issues:

History of previous treatments for the above symptoms:

Will this testing all or in part be used for educational/vocational remediation?  Yes  No

If yes, please explain:

How will understanding the neuropsychological status of this patient affect the treatment plan?

What are the patient's diagnostic rule outs/referral questions?

Test Planned	Date Requested	Time Requested
1.		
2.		
3.		
4.		
5.		
6.		

I verify that the information provided within this report is an accurate representation of the patient's status and that I am privileged to administer this procedure.

**STANDARD REVIEW:**

Standard 14-day time frame will be applied.

**EXPEDITED REVIEW:** By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

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