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SUBMIT TO
Utilization Management Department
Phone: 1.877.647.4848 Fax: 1.877.725.7751

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.

Clinician Signature Date

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

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