

Request for Authorization: Neuropsychological Testing

Please submit this form electronically using our preferred method at <https://www.availity.com>.
 This can also be submitted via fax to **1-844-430-1703**.

General information

| Member information | | | | | |
|-------------------------|--|---------------|--|----------------|--|
| Member name | | Date of birth | | Member ID | |
| Provider information | | | | | |
| Name of psychologist | | Provider ID | | Phone | |
| | | | | Fax | |
| Address | | Provider NPI | | Provider email | |
| Referral information | | | | | |
| Name of 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.

Clinical information (Please include any relevant medical records to support the request for testing.)

| | | | |
|--|--|---|---|
| <input type="checkbox"/> Traumatic brain injury, date: | <input type="checkbox"/> Encephalitis, date: | <input type="checkbox"/> Epilepsy and cognitive impairment suspected or documented, date: | <input type="checkbox"/> Multiple sclerosis and suspected or demonstrated cognitive impairment, date: |
|--|--|---|---|

* Availity is an independent company providing administrative services on behalf of Blue Medicare Advantage.

| | | | |
|---|---|---|--|
| <input type="checkbox"/> Anoxic/hypoxic brain injury, date: | <input type="checkbox"/> CVA, date: | <input type="checkbox"/> Psychosis, date: | <input type="checkbox"/> Major affective disorder, date: |
| <input type="checkbox"/> History of intracranial surgery, date: | <input type="checkbox"/> Brain tumor in remission or with slow progression, date: | <input type="checkbox"/> Neurosurgery planned for epilepsy control, date: | <input type="checkbox"/> Head injury with loss of consciousness, date: |
| <input type="checkbox"/> Confirmed neurotoxin exposure, date: | <input type="checkbox"/> Dementia suspected, date: | <input type="checkbox"/> Other, date: | <input type="checkbox"/> Other, date: |

Clinical assessment

| | | | |
|---|--|---|---|
| <input type="checkbox"/> Clinical interview with patient, date: | <input type="checkbox"/> Psychiatric evaluation, date: | <input type="checkbox"/> Structured developmental/ psychosocial history, date: | <input type="checkbox"/> EEG, date: |
| <input type="checkbox"/> Neurologic exam, date: | <input type="checkbox"/> Neurobehavioral exam, date: | <input type="checkbox"/> Consultation with school or other important persons, date: | <input type="checkbox"/> Medical evaluation, date: |
| <input type="checkbox"/> Consultation with PCP, date: | <input type="checkbox"/> Brief rating scales or inventories, date: | <input type="checkbox"/> Neuroimaging (CT, MRI, PET), date: | <input type="checkbox"/> 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 reasons for testing and the results?

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.

Provider signature: _____ Date: _____

For Blue Medicare Advantage use only:

| | | | |
|----------------------|------------------|-------------|-----|
| Date received: _____ | Auth from: _____ | 96116 _____ | hrs |
| 96119 _____ | hrs | | |
| Reference #: _____ | Auth to: _____ | 96118 _____ | hrs |
| 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.

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.