



Pre-Authorization Request for Neuropsychological Testing

Psychological and Patient Information

Patient Name:	Patient DOB:	Patient Phone:
Patient Address: Street:	Member ID Number:	
City: State: Zip:	Member Group Number:	

Provider Information

Name:	Degree/Lic.	Clinic Name/ID #
Address: Street:	Provider ID/NPI Number:	
City: State: Zip:	Provider Phone:	
Has the provider declared competency in psychological testing with their licensing board? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the provider Board Certified in Neuropsychology ? Yes, (<input type="checkbox"/> A.B.C.N. <input type="checkbox"/> A.B.N. <input type="checkbox"/> A.A. P. N.) <input type="checkbox"/> No		

Case Background

1. Has the patient undergone a psychiatric/psychological diagnostic interview? In most cases, an initial, diagnostic assessment must be completed before testing will be authorized <input type="checkbox"/> Yes (Date) _____ <input type="checkbox"/> No If yes, please attach evaluation.
2. Is the patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it medically necessary for testing to be done prior to discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No

Current / Provisional DSM IV Diagnosis:

<p>Axis I:</p> <p>Axis II:</p> <p>Axis III:</p>
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Fax form to: (651)662-0854 or mail form to:
Behavioral Health, PO Box 64668, St. Paul, MN 55164-0668

Purpose of Testing

1. What clinical question(s) will be answered by psychological/neuropsychological testing that cannot be answered through comprehensive diagnostic interview, gathering of collateral history and record review?

2. If the patient has undergone the proposed testing previously, why is repeat testing necessary at this time?

Date of previous testing:

Note: Brief rating scales, screening tools & questionnaires are considered incidental to the professional visit and should not be billed for separately.

Name of Test	Purpose of Test	CPT Code and Hours Requested (Request should include administration, scoring, interpretation and reporting)
		____ 96101 ____ 96116 ____ 96102 ____ 96118 ____ 96103 ____ 96119 _____ ____ 96120
		____ 96101 ____ 96116 ____ 96102 ____ 96118 ____ 96103 ____ 96119 _____ ____ 96120
		____ 96101 ____ 96116 ____ 96102 ____ 96118 ____ 96103 ____ 96119 _____ ____ 96120
Date Range: From _____ to _____		Total Hours: _____

I hereby attest that this information is true, accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____

If Technician CPT codes are requested the following must be completed by the supervising provider

I attest to the following:

- 1) The services billed under the technician CPT code(s) will be delivered by an individual who has the appropriate training and experience to administer these tests;
- 2) The services will be delivered under my direct personal supervision;
- 3) The services will be provided in the office/facility where I render services;
- 4) My employment and supervision of the Technician complies with all applicable state laws and regulations including those governing independently licensed mental health professionals.

Signature: _____ **Date:** _____

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