PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL ASSESSMENT SUPPLEMENTAL FORM

Provide specific information in context of each health plan's unique medical necessity criteria which are available on each plan's website or by request.

IDENTIFYING INFORMATION		
Dates of Service Requested: (Start)_____/ /	(End)_____/ /	
First Name:	Last Name:	MI:
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female Other:	
Policy Number:		
Health Plan:		
Date Form Submitted:	Preferred Language (if other than English):	
Servicing Clinician:	**Facility:**	
Phone Number:	TIN/NPI#:	
Name and Role of Referring Individual:		☐ Self Referred
Contact Person:	Best Time to Contact:	
Phone Number:	Fax:	
Email:		
Site Address:		
Requesting Clinician/Facility *(only if different than service provider)*:		
Phone Number:	TIN/NPI#:	
Contact Person:	Best Time to Contact:	
Phone Number:	Fax:	
Email:		

RELEVANT DIAGNOSTIC DATA	
Primary possible diagnosis which is the focus of this assessment:	
Possible comorbid or alternative diagnoses:	☐ None
List all other relevant medical/neurological or psychiatric conditions suspected or confirmed:	☐ None
Relevant results of imaging or other diagnostic procedures (provide dates for each):	☐ None

ASSESSMENT PLAN AND HISTORY

Psychological and Neuropsychological Test Evaluation Services		**Psychological and Neuropsychological Test Administration and Scoring**	
Please enter number of units requested		*Please enter number of units requested*	
Psychological Testing Evaluation Services, 1st hour	96130=___	Test Admin by Professional, first 30 minutes	96136=___
Additional hour (List Separately)	96131=___	Additional 30 minutes (List separately)	96137=___
Neuropsychological Testing Evaluation Service, 1st hour	96132=___	Test Admin by Technician, first 30 minutes	96138=___
Additional hour (List Separately)	96133=___	Additional 30 minutes (List separately)	96139=___
Automated Testing and Result	96146=___	Neurobehavioral status exam, 1st hour	96116=___
		Additional hour (List separately)	96121=___

List Likely Tests:

What suspected or confirmed factors suggested that assessment may require more time relative to test standardization samples:

☐ Depressed mood
☐ Low frustration tolerance
☐ Vegetative symptom
☐ Grapho-motor deficits
☐ Other (please specify):
☐ Physical symptoms or conditions (such as):
☐ Suspected processing speed deficits
☐ Performance Anxiety
☐ Receptive communication difficulties

Why is this assessment necessary at this time:

☐ Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms; and ruling out potential comorbidities.
☐ Results will help formulate or reformulate a comprehensive and optimally effective treatment plan.
☐ Assessment of treatment response or progress when the therapeutic response is significantly different than expected.
☐ Evaluation of a member's functional capability to participate in health care treatment
☐ Determine the clinical and functional significance of brain abnormality.
☐ Dangerousness Assessment
☐ Assess mood and personality characteristics impact experience or perception of pain.
☐ Other (describe):

Has a standard clinical evaluation been completed in the past 12 months? ☐Y ☐N

If yes, when and by whom:

If no, explain why a standard clinical evaluation cannot answer the assessment questions:

Date of last known assessment of this type: ☐ No prior testing

If testing in past year, why are these services necessary now:

☐ Unexpected change in symptoms
☐ Evaluate response to treatment
☐ Assess function
☐ Previous assessment is likely invalid
☐ Other (please specify):

Are units requested for the primary purpose of differentiating between medical, psychiatric conditions, learning disorders and/or guiding health care services? ☐Y ☐N

Are the units requested for the primary purpose of determining special needs educational programs? ☐Y ☐N

Are the units requested to answer questions of law under a court order? ☐Y ☐N

Currently known symptoms and functional impairments of the patient that warrant this assessment:

RELEVANT MENTAL HEALTH/SUD HISTORY

Relevant Mental Health History: ☐ None

Is substance use disorder suspected? ☐Y ☐N

If yes, how many days of sobriety:

Are medication effects a likely and primary cause of the impairment being assessed? ☐Y ☐N

If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly? ☐Y ☐N

If no, explain why testing is necessary:

If the primary diagnosis is ADHD, indicate why the evaluation is not routine:

- ☐ Previous treatment(s) have failed and testing is required to reformulate the treatment plan
- ☐ A conclusive diagnosis was not determined by a standard examination
- ☐ And/or specific deficits related to or co-existing with ADHD need to be further evaluated
- ☐ Other (please specify):

Signature of requesting clinician: