SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759

PHONE 1.844.385.2192
Neuropsychological testing fax 1.844.774.2363
Psychological testing fax 1.866.593.1955

INPATIENT AND OUTPATIENT NEUROPSYCHOLOGICAL AND PSYCHOLOGICAL TESTING

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

PATIENT INFORMATION

Name:_____

Date of Birth: _____

Member ID#: _____

Social Security #: _____

PROVIDER INFORMATION

Provider Name: _____

Group Name: _____

Phone:_____

Fax: _____

NPI: _____

TIN: _____

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:

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

If yes, please explain:

How will testing be used to affect the treatment plan?

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

PLEASE CHECK THE APPROPRIATE NEUROPSYCHOLOGICAL TESTING CODE (SELECTE ONLY ONE)

☐ 96116 ☐ 96118 ☐ 96119 ☐ 96120

Test Planned (please add one test per line)	Time required to complete test

PLEASE CHECK THE APPROPRIATE PSYCHOLOGICAL TESTING CODE (SELECT ONLY ONE)

☐ 96101 ☐ 96110 ☐ 96111 ☐ H2000

Test Planned (please add one test per line)	Time required to complete test

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.

Clinician Signature _____ Clinician Name _____ Date _____

Referral Source _____ Date Received _____ Date Processed _____