SUBMIT TO
Utilization Management Department
PHONE 1.844.385.2192
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#: _____

SocialSecurity #: _____

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

If yes, please explain:

Will this testing, all or in part, be used for legal concerns? ☐ 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?

NEUROPSYCHOLOGICAL TESTING

Test Planned	Time Required to Complete Test

PSYCHOLOGICAL TESTING

Test Planned	Time Required to Complete Test

I verfiy that the information provided within this report is an accurate representation of the patient's status and that I am priviledged to administer this procedure.

Clinician Signature

Clinician Name

Date

Referal Source

Date Received

Date Processed