BlueCross BlueShield Nebraska

# Psychological/Neuropsychological Testing Request Form

***(Form should be used for members of all ages)***

**Please fax the completed request form to the Utilization Management Department (UMD) at 402-343-3444.**

For questions regarding this authorization, please call the UMD at 402-390-1870 or 800-247-1103.

A.

Patient Name _____ Date of Birth _____

Subscriber Name _____ Blue Cross and Blue Shield of Nebraska ID # _____

B.

Practitioner Name _____ Credentials/Billing Provider NPI Number _____

Provider Mailing Address _____ Provider Telephone Number _____

Provider City, State, Zip _____ Provider Fax Number _____

If provisionally licensed, name of supervising provider: _____

C.

(i.) Who initiated the referral? _____

If physician, list specialty: _____

(ii.) Has a comprehensive initial evaluation of the patient been completed? ☐ Yes ☐ No
If yes, please attach evaluation.
If rating scales have been completed, please attach.

(iii.) What referral question(s) need to be answered that cannot be answered by a diagnostic interview, medical/neurological consult or review of medical records?

_____

_____

_____

(iv.) Has the patient been evaluated by a psychiatrist? ☐ Yes ☐ No If yes, list date(s): _____

Current medications: _____

_____

D.

Current DSM Edition or ICD Diagnosis (ICD-10 Codes):

_____

_____

E. Patient History

Please provide a summary of patient's psychiatric and medical history with dates, prior testing and dates, description of symptoms and functional impairment, family psychiatric and medical history:

_____

_____

_____

Does patient live alone? ☐ Yes ☐ No With family? ☐ Yes ☐ No

Has any family member ever been interviewed? ☐ Yes ☐ No

If not, why?

_____

**Please attach documentation if necessary to answer the above. Thank you.**

F. Describe how proposed testing will enhance treatment and impact future behavioral treatment.
Is patient currently in treatment: ☐ Yes ☐ No If yes, specify modality (e.g., individual, family, group):

_____

_____

_____

G. Are there reasons, other than psychological explanations, for current behavior/symptoms? (thyroid dysfunction, closed head injury, medications, poisoning, etc.)

_____

_____

_____

H. Please list total testing hours requested. Please note: 4 hours or less per calendar year, does not need reviewed.

CPT codes included: 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139 Hours Required:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Provider Signature: _____ Date: _____