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):

____

____

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

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 test(s) to be administered:

Specific Test(s) Planned (include CPT code(s)):	Hours Required:

Provider Signature: ______________________________ Date: ____________