

# Request for Authorization: Neuropsychological Testing

Submit completed form electronically using our preferred method at **Availity** or by fax to **1-833-974-0059**.

Today's date:	
Contact at provider's office:	Secure fax:
Name of requestor:	Phone:
<b>Note:</b> Please provide appropriate contact information, including best working phone number for Humana staff to contact you if we need clarification or additional information to complete the request.	

## Member information

Last name:		First name:	
Humana ID:	Medicaid ID:	Date of birth:	
Parent/guardian name:			Phone:
Member's living arrangements:			
At home with guardian		Group home	Foster home
Authorization reference number (if applicable):			

## Requesting provider/facility

Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

## Treating/servicing provider

Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

## Diagnosis code(s) and date(s) of service (DOS)

ICD-10*:	ICD-10*:	ICD-10*:	ICD-10*:
Start date of service:		End date of service:	

\* ICD-10 codes are from the International Classification of Diseases, Tenth Edition.



### Service code(s)

Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:

Neuropsychological testing, also known as psychometric testing, is a comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders.

This testing may be used to augment a comprehensive medical history and physical examination, as well as a neurological investigation of certain conditions. Neuropsychological testing is considered medically necessary when there is evidence to suggest that the test results will have a timely and direct impact on the member's treatment plan for certain indications. Repeat testing to track the status of an illness or the recovery progress is subject to individual case consideration but generally is not warranted.

### Clinical information

Anoxic/hypoxic brain injury, date:
Brain tumor in remission or with slow progression, date:
Confirmed neurotoxin exposure, date:
Cerebrovascular accident, date:
Dementia suspected, date:
Encephalitis, date:
Epilepsy and cognitive impairment suspected or documented, date:
Head injury with loss of consciousness, date:
Intracranial surgery, date:
Major affective disorder, date:
Multiple sclerosis and suspected or demonstrated cognitive impairment, date:
Neurosurgery planned for epilepsy control, date:
Psychosis, date:
Traumatic brain injury, date:
Other, date:

### Clinical assessment

Brief rating scales or inventories, date:

Clinical interview with patient, date:

Consultation with school officials or other important persons, date:

Consultation with primary care provider, date:

Electroencephalogram, date:

Interview with family member(s), date:

Medical evaluation, date:

Neurologic exam, date:

Neurobehavioral exam, date:

Neuroimaging (CT, MRI, PET), date:

Psychiatric evaluation, date:

Structured developmental/psychosocial history, date:

**Date of clinical interview:**

**Enter other pertinent history or clinical information relevant to this request for neuropsychological testing.**

Has the patient had previous psychological/neuropsychological testing?      Yes      No

If yes, date of testing: \_\_\_\_\_

What were the reasons and results for testing?

List medication(s) the patient is taking or mark the box if none.      None

Have medication effects been ruled out as a cause of cognitive impairment?      Yes      No

Have alcohol and/or illicit substances been ruled out as a cause of cognitive impairment?      Yes      No

Enter the patient's substance use history to date or mark the box if none.      None

What are the specific questions to be answered by neuropsychological testing that cannot be determined from the above services? How will the test results impact this patient's treatment?

**Provider signature:**

**Date:**