

Please check one of the above. When complete, fax to 1-833-329-8601.

Please type or print clearly. Incomplete and illegible forms will delay processing.

1. Member information			
Member name:	Eligibility ID #:	SSN:	DOB:
Member address:			
City, state, ZIP code:			Phone:
Who referred member for treatment?			
2. Treating provider information			
Name (with credentials):		NPI #:	Phone:
Address:			
City, state, ZIP code:			Fax:
Group name or ID number:		Contact name:	
Treating provider signature:			
3. Testing requested			
<input type="checkbox"/> Neuropsychological: Insert service codes being requested:			
<input type="checkbox"/> Psychological: Insert service codes being requested:			
Referral reason and functional impairment:			
How will the anticipated results affect the member's treatment plan?			
4. DSM-5 diagnosis			
List all mental health, substance use, and medical diagnoses:			
5. Current symptoms prompting request for testing			
<input type="checkbox"/> Anxiety <input type="checkbox"/> Psychosis or hallucinations <input type="checkbox"/> Mood instability <input type="checkbox"/> Bizarre behavior <input type="checkbox"/> Inattention	<input type="checkbox"/> Hyperactivity <input type="checkbox"/> Withdrawal or social isolation <input type="checkbox"/> Unprovoked agitation or aggression <input type="checkbox"/> Self-injurious behaviors <input type="checkbox"/> Eating disorder symptoms	<input type="checkbox"/> Behaviors impacting activities of daily living (ADLs) <input type="checkbox"/> Depression <input type="checkbox"/> Poor academic or employment performance <input type="checkbox"/> Other: _____	
6. Current medications			
List with dosages or attach sheet:			
7. Assessments to date			
<input type="checkbox"/> No assessment procedures performed to date <input type="checkbox"/> Direct observation <input type="checkbox"/> Assessment by mental health professionals <input type="checkbox"/> Consultation with others <input type="checkbox"/> Structured interview <input type="checkbox"/> Interview with family or guardians		<input type="checkbox"/> Medical evaluation <input type="checkbox"/> Review of records of previous treatment <input type="checkbox"/> Clinical interview with patient <input type="checkbox"/> Brief inventories or rating scales <input type="checkbox"/> Consultation with patient's provider <input type="checkbox"/> Other (please list): _____	

Neuropsychological/Psychological Testing Request



Please answer the following. Attach additional pages and records if necessary.

Patient medical and psychiatric history: _____

Family medical and psychiatric history: _____

Describe any neurological events and/or neuro-developmental concerns: _____

History of psychological testing and results or findings: _____

8. Description of testing request		
Test to be administered	Time required (administration of test, scoring, interpretation, and report preparation)	Comments

Additional information