LHV
LOWER HUDSON VALLEY E.A.P
Mental Health & Substance Use Disorder Services

Request for Authorization: Neuropsychological Testing

General information

Member name:			
Member ID:		Member DOB:	
Name of servicing provider:			
Provider email:			
Provider ID:		Provider NPI:	
Provider address:			
Phone number:		Fax number:	
Name of referral source:			
Referral source specialty:		Referral source phone:	
Referral source address:			

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 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 recovery progress is subject to individual case consideration but is generally not warranted.

Clinical assessment

☐ Consultation with PCP, date:	☐ Medical evaluation, date:	☐ Clinical interview with patient, date:	☐ Interview with family member(s), date:
☐ EEG, date:	☐ Psychiatric evaluation, date:	☐ Neurobehavioral exam, date:	☐ Structured developmental/psychosocial history, date:
☐ Neurologic exam, date:	☐ Neuroimaging (CT, MRI, PET), date:	☐ Brief rating scales or inventories, date:	☐ Consultation with school or other important persons, date:

Clinical information (Please include any relevant medical records to support the request for testing.)

☐ Neurosurgery planned for epilepsy control, date:	☐ Brain tumor in remission or with slow progression, date:	☐ Epilepsy and cognitive impairment suspected or documented, date:	☐ Multiple sclerosis and suspected or demonstrated cognitive impairment, date:
☐ Traumatic brain injury, date:	☐ History of intracranial surgery, date:	☐ Confirmed neurotoxin exposure, date:	☐ Head injury with loss of consciousness, date:
☐ Encephalitis, date:	☐ Dementia suspected, date:	☐ Anoxic/hypoxic brain injury, date:	☐ Major affective disorder, date:
☐ CVA, date:	☐ Psychosis, date:	☐ Other: date:	☐ Other: 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 for testing and the results?	
List the 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 substance effects 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?
Enter ICD-10 diagnoses under evaluation:

Neuropsychological tests and services requested

CPT® code(s)	Units requested	Test names/service description

Total units requested:		Total time requested:	

Provider signature:	Date:

Authorization for routine outpatient care is not required for network providers treating eligible members. Authorization for neuropsychological testing is subject to verification of member eligibility and is not a guarantee of payment.

Note: We are unable to process illegible or incomplete requests.