

# PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL ASSESSMENT SUPPLEMENTAL FORM

**Provide *specific* information in context of each health plan's unique medical necessity criteria which are available on each plan's website or by request.**

IDENTIFYING INFORMATION		
Dates of Service Requested: Start: ____/____/____      End: ____/____/____		
First Name:	Last Name:	MI:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female   Other: _____	
Policy Number:		
Health Plan:	Health Plan Fax #:	
Date Form Submitted:		
<b>Servicing Clinician:</b>		<b>Facility:</b>
Address:		
Phone Number:	NPI:	TIN:
Name and Role of Referring Individual:		<input type="checkbox"/> Self Referred
Contact Person:	Best Time to Contact:	
Phone Number:	Fax:	
Email:		
<b>Requesting Clinician/Facility (only if different than service provider):</b>		
Address:		
Phone Number:	NPI:	TIN:
Contact Person:	Best Time to Contact:	
Phone Number:	Fax:	
Email:		
RELEVANT DIAGNOSTIC DATA		
Primary possible diagnosis which is the focus of this assessment?		
Possible comorbid or alternative diagnoses:		<input type="checkbox"/> None
List all other relevant medical/neurological or psychiatric conditions suspected or confirmed:		<input type="checkbox"/> None
Relevant results of imaging or other diagnostic procedures (provide dates for each):		<input type="checkbox"/> None
CPT CODES REQUESTED		
Psychological Testing Evaluation (per 60 minutes) 96130 = _____ 96131 = _____	Neuropsychological Testing Evaluation (per 60 minutes) 96132 = _____ 96133 = _____	Neurobehavioral Status Evaluation 96116 = _____ 96121 = _____
Test Administration (per 30 minutes) 96136 = _____ 96137 = _____ 96138 = _____ 96139 = _____	Test Administration (per 30 minutes) 96136 = _____ 96137 = _____ 96138 = _____ 96139 = _____	
List Likely Tests:		
What suspected or confirmed factors suggest that assessment may require more time relative to test standardization samples?		
<input type="checkbox"/> Depressed mood <input type="checkbox"/> Low frustration tolerance <input type="checkbox"/> Vegetative symptom <input type="checkbox"/> Grapho-motor deficits <input type="checkbox"/> Suspected processing speed deficits	<input type="checkbox"/> Physical symptoms or conditions such as: _____  <input type="checkbox"/> Performance anxiety <input type="checkbox"/> Receptive communication difficulties <input type="checkbox"/> Other: _____	

Why is this assessment necessary at this time?

Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms; and ruling out potential comorbidities.

Results will help formulate or reformulate a comprehensive and optimally effective treatment plan.

Assessment of treatment response or progress when the therapeutic response is significantly different than expected.

Evaluation of a member's functional capability to participate in health care treatment.

Determine the clinical and functional significance of brain abnormality.

Dangerousness Assessment.

Assess mood and personality characteristics impact experience or perception of pain.

Other (describe): \_\_\_\_\_

Has a standard clinical evaluation been completed in the past 12 months?  Y  N

If yes, when and by whom?

Explain why a standard clinical evaluation was not or would not be able to answer the assessment questions.

Date of last known assessment of this type: \_\_\_\_\_  No prior testing

If testing in past year, why are these services necessary now?

Unexpected change in symptoms  Previous assessment is likely invalid

Evaluate response to treatment  Other (specify): \_\_\_\_\_

Assess function \_\_\_\_\_

Are units requested for the primary purpose of differentiating between medical, psychiatric conditions, and/or learning disorders and/or guiding *health care services*?  Y  N

Are the units requested for the primary purpose of determining special needs educational programs?  Y  N

Are the units requested to answer questions of law under a court order?  Y  N

What are the patient's currently known symptoms and functional impairments that warrant this assessment? If neuropsych assessment is requested, clearly describe specific cognitive impairments and suspected brain insult.

**RELEVANT MENTAL HEALTH/SA HISTORY**

Relevant Mental Health History: \_\_\_\_\_  None

Is substance use/dependence suspected?  Y  N | If yes, how many day of sobriety? \_\_\_\_\_

Are medication effects a likely and primary cause of the impairment being assessed  Y  N

If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly  Y  N

If no, explain why testing is necessary.

If the primary diagnosis is ADHD, indicate why the evaluation is not routine:

Previous treatment(s) have failed and testing is required to reformulate the treatment plan

A conclusive diagnosis was not determined by a standard examination and/or

Specific deficits related to or co-existing with ADHD need to be further evaluated

Other: \_\_\_\_\_

Signature of requesting clinician: \_\_\_\_\_

**Providers may attach any additional data relevant to medical necessity criteria.**