



Authorization Request Form

# Neuro/Psychological Testing

An intake evaluation must be completed before a request for testing will be considered. Testing for learning disability, attention deficit disorders and disability evaluations is not covered. Rating scales, checklists, inventories and questionnaires are not reimbursed as testing.

Patient's Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_ ID# \_\_\_\_\_

**\*Please attach a copy of the psychological intake and fax all to (715) 852-5738.**

Diagnosis Code(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the patient had previous testing?  Yes  No

If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_

What specific questions will be answered by the evaluation?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Describe how the evaluation will help to implement the treatment plan:

\_\_\_\_\_  
\_\_\_\_\_

Describe what other strategies/treatments have failed:

\_\_\_\_\_  
\_\_\_\_\_

Specify the proposed measures and rationale for use:

Measure Name: \_\_\_\_\_ CPT Code: \_\_\_\_\_ Hours: \_\_\_\_\_

Rationale: \_\_\_\_\_

Measure Name: \_\_\_\_\_ CPT Code: \_\_\_\_\_ Hours: \_\_\_\_\_

Rationale: \_\_\_\_\_

Measure Name: \_\_\_\_\_ CPT Code: \_\_\_\_\_ Hours: \_\_\_\_\_

Rationale: \_\_\_\_\_

Measure Name: \_\_\_\_\_ CPT Code: \_\_\_\_\_ Hours: \_\_\_\_\_

Rationale: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Facility Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**The submission of supporting clinical documentation/plan of care is required with this form.**

**Privacy and Confidentiality:**

The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 866-364-0892 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.