Trilogy
Homegrown Health Care

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.