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| **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. Please type an “x” or type content into gray boxes only. |

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| **IDENTIFYING INFORMATION** |
| Dates of Service Requested (MM/DD/YYYY):  | Start : |       | End: |       |
| First Name:  |       | Last Name: |       | MI: |       |
| Date of Birth (MM/DD/YYYY): |       | Gender: Other:  |       | Male |       | Female | Other : |       |
| Policy Number: |       |
| Health Plan: |       |
| Date Form Submitted (MM/DD/YYYY): |       |
| **Servicing Clinician:** |       | **Facility:** |       |
| Phone Number: |       | NPI/TIN#: |       |
| Name and Role of Referring Individual: |       |       | Self-Referred |
| Contact Person: |       | Best Time to Contact: |       |
| Phone Number: |       | Fax: |       |
| Email: |       |
| **Requesting Clinician/Facility *(only if different than service provider)*:** |       |
| 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:  |       |
| None: |       |
| List all other relevant medical/neurological or psychiatric conditions suspected or confirmed:  |       |
| None: |       |
| Relevant results of imaging or other diagnostic procedures (provide dates for each):  |       |
| None: |       |
| **ASSESSMENT PLAN AND HISTORY** |
| Total hours of authorization for testing (please list below for each category):  |
| Psychological Testing: | Neuropsychological Testing: | Neuro-Behavioral Evaluation: |
| 96101 = |       | 96118 = |       | 96116 = |       |
| 96102 = |       | 96119 = |  | (Note: Preauthorization not required by most plans) |
| 96103 = |       | 96120 = |       |  |
| List Likely Tests: |       |
| What suspected or confirmed factors suggest that assessment may require more time relative to test standardization samples? |
| Depressed mood: |       | Performance anxiety: |       |  |
| Low frustration tolerance: |       | Receptive communication difficulties: |       |  |
| Vegetative symptom: |       | Physical symptoms or conditions such as: |       |
| Grapho-motor deficits: |       | Other: |       |
| Suspected processing speed deficits: |       |

1 *(continued on next page)*

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| Why is this assessment necessary at this time (Please make a check or answer below)? |
|       | Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness ofsymptoms; 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): |       |
| If yes, when and by whom? |       |
| If no, explain why a standard clinical evaluation cannot answer the assessment questions.  |       |
| Date of last known assessment of this type (MM/DD/YYYY):  |       |       | No prior testing |
| If testing in past year, why are these services necessary now (please answer below)? |
|       | 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*? |       | Yes |       | No |
| Are the units requested for the primary purpose of determining special needs educational programs?  |       | Yes |       | No |
| Are the units requested to answer questions of law under a court order?  |       | Yes |       | No |
| What are the patient’s currently known symptoms and functional impairments that warrant this assessment? |       |
| **RELEVANT MENTAL HEALTH/SA HISTORY** |
| Relevant Mental Health History: |        |       | None |
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| Is substance abuse/dependence suspected? |       | Yes |       | No | If yes, how many day of sobriety? |       |
| Are medication effects a likely and primary cause of the impairment being assessed?  |       | Yes |       | No |
| If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly? |
|       | Yes |       | No |  |
| If no, explain why testing is necessary? |       |
| If the primary diagnosis is ADHD, indicate why the evaluation is not routine (Please check answers below) |
|       | 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: |       |

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| Signature of requesting clinician:       ***Providers may use email or fax submission if additional data relevant to medical necessity criteria needs to be attached*** |

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