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.

Clear Form

IDENTIFYING INFORMATION

Dates of Service Requested: Start:____/____/____ End:____/____/____		
First Name:	Last Name:	MI:
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female Other: _____	
Policy Number:		
Health Plan:		
Date Form Submitted:		
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:

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
☐ Low frustration tolerance
☐ Vegetative symptom
☐ Grapho-motor deficits
☐ Suspected processing speed deficits
☐ Physical symptoms or conditions such as: _____
☐ Performance anxiety
☐ Receptive communication difficulties
☐ Other:

(continued on next page)

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?

If no, explain why a standard clinical evaluation cannot 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

☐ Evaluate response to treatment

☐ Assess function

☐ Previous assessment is likely invalid

☐ Other (specify): _____

_____

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?

RELEVANT MENTAL HEALTH/SA HISTORY

Relevant Mental Health History: ☐ None

Is substance abuse/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: _____

allways℠ HEALTH PARTNERS

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

Please fax to AllWays Health Partners at 617-586-1700.