## 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:	<u></u>	
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 DIA	AGNOSTIC 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 suspe	ected or confirmed:	
Relevant results of imaging or other diagnostic procedures (provide dates	for each):	
ASSESSMENT PI	AN AND HISTORY	
Total hours of authorization for testing:	Name Debasional Contration	
Psychological Testing: Neuropsychological 96101 = 96118 = 96118		
96102 = 96119 =	(Note: Preauthorization not required by most plans)	
96103 = 96120 =		
List Likely Tests:		
What suspected or confirmed factors suggest that assessment may requir	e more time relative to test standardization samples?	
□ Depressed mood	□ Physical symptoms or conditions such as:	
□ Low frustration tolerance	,,	
□ Vegetative symptom	□ Performance anxiety	
☐ Grapho-motor deficits	Receptive communication difficulties	
☐ Suspected processing speed deficits	□ Other:	

□ Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms and fulling 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.  □ Determine the clinical and functional significance of brain abnormality.  □ Determine the clinical and functional significance of brain abnormality.  □ Determine the clinical and functional significance of brain abnormality.  □ Determine the clinical and personality characteristics impact experience or perception of pain.  □ Other (describe):  □ Research and personality characteristics impact experience or perception of pain.  □ Other (describe):  □ Research and by whom?  If yes, when and by whom?  If yes, when and by whom?  If no, explain why 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:  □ Research and the past year, why are these services necessary now?  □ Unexpected change in symptoms  □ Previous assessment is likely invalid  □ If yes a standard clinical evaluation and the past 12 months? □ Previous assessment is likely invalid  □ Research and the past year, why are these services necessary now?  □ Unexpected change in symptoms  □ Previous assessment is likely invalid of the primary purpose of determining special needs educational programs? □ Y □ N  Are the units requested for the primary purpose of determining special needs educational programs? □ 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 faw under a count order? □ Y □ N  Are the units requested to an experiment of the primary purpo	Why is this assessment necessary at this time?		
Assessment of treatment response or progress when the therapeutic response is significantly different than expected.   □ valuation 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):			
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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?   Previous assessment is likely invalid   Voter (specify):   Voter (speci	☐ Other (describe):		
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If testing in past year, why are these services necessary now?    Drexpected change in symptoms   Previous assessment is likely invalid     Evaluate response to treatment   Other (specify):	If no, explain why a standard clinical evaluation cannot answer the assessm	ent questions.	
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$\label{eq:control_problem} \square \ Specific \ deficits \ related \ to \ or \ co-existing \ with \ ADHD \ need \ to \ be \ further \ evaluated$	$\square$ Specific deficits related to or co-existing with ADHD need to be further	evaluated	
	Other:		
Othory			

Signature of requesting clinician: \_

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

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