

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.

IDENTIFYING INFORMATION		
Dates of Service Requested: Start: ____/____/____ End: ____/____/____		
First Name:	Last Name:	MI:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Other: _____	
Policy Number:		
Health Plan:		
Date Form Submitted:		
Servicing Clinician:		Facility:
Phone Number:	NPI/TIN#:	
Name and Role of Referring Individual:		<input type="checkbox"/> 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:		<input type="checkbox"/> None
List all other relevant medical/neurological or psychiatric conditions suspected or confirmed:		<input type="checkbox"/> None
Relevant results of imaging or other diagnostic procedures (provide dates for each):		<input type="checkbox"/> 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?		
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Physical symptoms or conditions such as:	
<input type="checkbox"/> Low frustration tolerance	_____	
<input type="checkbox"/> Vegetative symptom	<input type="checkbox"/> Performance anxiety	
<input type="checkbox"/> Grapho-motor deficits	<input type="checkbox"/> Receptive communication difficulties	
<input type="checkbox"/> Suspected processing speed deficits	<input type="checkbox"/> Other:	

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 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? 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: _____



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

Please fax to Neighborhood Health Plan at 617-586-1700.