MDwise
A McLaren Company

SUBMIT TO:
NAME OF DEPARTMENT
ADDRESS
CITY, ST ZIP CODE
FAX:

INDIANA NEURO-PSYCHOLOGICAL TESTING REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Member Information

Patient Name: ______________________

Health Plan: ______________________

DOB: ______________________

SS#: ______________________

Patient ID#: ______________________

Referral Source: ______________________

Provider Information

(Please indicate by checking below, whether requested services should be authorized to the provider or agency.)

☐ Provider
☐ Group/ Agency Name: ______________________

Professional Credential: ☐ MD ☐ PhD ☐ Other: _____

Physical Address: ______________________

PHONE: ______________ FAX: ______________

Medicaid/TPI/NPI#: ______________ Tax ID#: ______________

Referral Reason/Question:

Testing will not be authorized under any of the following conditions:

1. Testing is primarily for educational or vocational purposes.
2. Testing is primarily for legal purposes.
3. The tests requested are experimental or have no documented validity.
4. The time requested to administer the testing exceeds established time parameters.
5. Testing is routine for entrance into a treatment program.

Is this testing required for educational purposes, behavioral health purposes, or both?

Explain

State how the anticipated results of the testing will effect the patient's treatment plan:

DSM IV Axis

AXIS I	R/O	R/O
AXIS II		
AXIS III		
AXIS IV		
AXIS V	CURRENT	PAST YEAR

Danger to Self or Others? ☐ Yes ☐ No
If Yes, please explain:

MSE Within Normal Limits? ☐ Yes ☐ No
If No, please explain:

List Current Medications:

Name/Strength	**Directions**

What are the Current Symptoms Prompting the Request for Testing?

☐ Anxiety
☐ Depression
☐ Inattention
☐ Confusion
☐ Hypoactivity
☐ Hyperactivity
☐ Psychosis/Hallucinations
☐ Bizarre Behavior
☐ Unprovoked Agitation/Aggression
☐ Self-Injurious Behavior
☐ Eating Disorder Symptoms
☐ Withdraw/Poor Social Interaction
☐ Mood Instability
☐ Changes in memory capacity
☐ Changes in cognitive capacity
☐ Behavior Problems affecting life functions (e.g., school, home)
☐ Poor Academic Performance
☐ Other, List ______________________

Comment/Explain:

Was a Behavioral Health Evaluation completed (e.g., 90801)?

☐ Yes ☐ No Date: ____________________

Results:
____
____
____

Was Previous Psychological or Neuropsychological Testing Conducted?

☐ Yes ☐ No Date: ____________________

Basic Focus and Results: ___________________________________
____
____
____

HISTORY

When was the patient's last physical examination?

If ADHD is a diagnostic rule out, please indicate results of standardized ADHD rating scales, if available:

☐ Positive ☐ Negative ☐ Inconclusive ☐ Not Applicable

Comment/Explain:

Start Date MM/DD/YY	Stop Date MM/DD/YY	CPT code	Modifier(s)	Units Requested

Please list the tests planned to answer the clinical questions:

Test	Reason for Use	Educational Yes/No	Number of Units Requested for Test	Number of Units Approved for Test

Indicate the total number of units (hours) requested: ____________

Provider Signature: ____

Date: ______________________