MDwise BEHAVIORAL HEALTH

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 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	Hours Requested

Please list the tests planned to answer the clinical questions:

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

Indicate the total number of units and hours requested: _____

Provider Signature:_____

Date: _____