

## ***Request for Authorization: Neuropsychological Testing***

Please submit this form electronically using our preferred method at <https://providers.amerigroup.com/NJ>. You may also submit via fax to 1-800-505-1193.

### **General information**

Member name:	DOB:	Age:	Member ID:
Name of psychologist:	Provider number:	Phone:	Fax:
Address:		Provider NPI:	Provider email:
Referral source:		Specialty:	
Address:		Phone:	

Neuropsychological testing, also known as psychometric testing, is a comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders. This testing may be used to augment a comprehensive medical history and physical examination as well as neurological investigation of certain conditions. Neuropsychological testing is considered medically necessary when there is evidence to suggest that the test results will have a timely and direct impact on the member's treatment plan for certain indications. Repeat testing to track the status of an illness or recovery progress is subject to individual case consideration but is generally not warranted. For more information, see the *Clinical Utilization Management Guidelines* at [https://medicalpolicies.amerigroup.com/medicalpolicies/guidelines/gl\\_pw\\_a053761.htm](https://medicalpolicies.amerigroup.com/medicalpolicies/guidelines/gl_pw_a053761.htm).

**Important note:** You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

**Clinical information**

Please include any relevant medical records to support the request for testing.

<input type="checkbox"/> Traumatic brain injury Date: _____	<input type="checkbox"/> Encephalitis Date: _____	<input type="checkbox"/> Epilepsy and cognitive impairment suspected or documented Date: _____	<input type="checkbox"/> Multiple sclerosis and suspected or demonstrated cognitive impairment Date: _____
<input type="checkbox"/> Anoxic/hypoxic brain injury Date: _____	<input type="checkbox"/> CVA Date: _____	<input type="checkbox"/> Psychosis Date: _____	<input type="checkbox"/> Major affective disorder Date: _____
<input type="checkbox"/> History of intracranial surgery Date: _____	<input type="checkbox"/> Brain tumor in remission or with slow progression Date: _____	<input type="checkbox"/> Neurosurgery planned for epilepsy control Date: _____	<input type="checkbox"/> Head injury with loss of consciousness Date: _____
<input type="checkbox"/> Confirmed neurotoxin exposure Date: _____	<input type="checkbox"/> Dementia suspected Date: _____	<input type="checkbox"/> Other Date: _____	<input type="checkbox"/> Other Date: _____

**Clinical assessment**

<input type="checkbox"/> Clinical interview with patient Date: _____	<input type="checkbox"/> Psychiatric evaluation Date: _____	<input type="checkbox"/> Structured developmental/ psychosocial history Date: _____	<input type="checkbox"/> EEG Date: _____
<input type="checkbox"/> Neurologic exam Date: _____	<input type="checkbox"/> Neurobehavioral exam Date: _____	<input type="checkbox"/> Consultation with school or other important persons Date: _____	<input type="checkbox"/> Medical evaluation Date: _____
<input type="checkbox"/> Consultation with PCP Date: _____	<input type="checkbox"/> Brief rating scales or inventories Date: _____	<input type="checkbox"/> Neuroimaging (CT, MRI, PET) Date: _____	<input type="checkbox"/> Interview with family member(s) Date: _____

Date of clinical interview: \_\_\_\_\_

Enter other pertinent history or clinical information relevant to this request for neuropsychological testing.

Has the patient had previous psychological/neuropsychological testing?  Yes  No

If yes, date of testing: \_\_\_\_\_

What were the results and reasons for testing?

List the medication(s) the patient is taking or mark the box if none.  None

Have medication effects been ruled out as a cause of cognitive impairment?  Yes  No

Have alcohol and/or illicit substance effects been ruled out as a cause of cognitive impairment?

Yes  No

Enter the patient's substance abuse history to date or mark the box if none.  None

What are the specific questions to be answered by neuropsychological testing that cannot be determined from the above services? How will the test results impact this patient's treatment?

Enter ICD-10 diagnoses under evaluation.

**Neuropsychological tests requested**

Please list the tests you are requesting and expected administration time. For tests with multiple versions, specify which one. If you are administering selected subtests, please indicate which ones. Please attach a separate sheet if necessary.

Total time requested in hours: \_\_\_\_\_

Provider signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**For Amerigroup Community Care use only:**

Date received:	Auth from:	96116 _____ hours	96119 _____ hours
Reference #:	Auth to:	96118 _____ hours	Other:

Authorization for routine outpatient care is not required for network providers treating eligible members. Authorization for neuropsychological testing is subject to verification of member eligibility and is not a guarantee of payment.

**Note:** We are unable to process illegible or incomplete requests.