MHNet
BEHAVIORAL HEALTH

PRECERTIFICATION FOR NEUROPSYCHOLOGICAL TESTING

In order to be authorized, neuropsychological testing must be needed to establish a differential diagnosis that is crucial to establishing or modifying a treatment plan. Before requesting authorization for neuropsychological testing you must complete a face-to-face evaluation of sufficient detail to answer the questions on the authorization form.

Testing requested for legal, employment, vocational, or educational purposes is most often not a covered benefit. For treatment planning purposes, please be advised that each hour of testing counts as the equivalent of one outpatient visit. Accordingly, testing is encouraged only when clearly indicated and necessary for treatment. This report must be received and certified by MHNet prior to testing. If testing is deemed urgent (less than one week's notice), the request can be done by calling MHNet at 1-800-835-2094.

PATIENT NAME ______________________ D.O.B. ______________ AGE ____________

INSURANCE PLAN ______________________ ID # ______________________

INSURED'S NAME ______________________ EMPLOYER GROUP ______________________

Current Diagnoses under evaluation (DSM 5)

Diagnosis (primary) __________ Comorbid medical diagnosis __________ Psychosocial Factors __________

R/O diagnoses ______________ ICD-9 or 10 diagnosis ______________________

____

Patient referred to Requesting Psychologist by: (Name, Degree, Specialty, Phone)

Name ______________________ Degree ______________________

Phone ______________________ Specialty ______________________

1. **Clinical interview data: include relevant psycho/social/behavioral history, current symptoms, impairments in functioning, mental status exam, etc.:**

2. **Purpose of testing (include referral question, differential diagnostic issues to be addressed, how treatment plan will be affected by results of testing):**

3. **Prior test results (medical and mental health); include diagnosis, dates of prior testing and names of the specific test that were performed):**

4. **Which of the following diagnostic / assessment techniques have been completed?**

- [ ] Diagnostic Interview
- [ ] Clinical Review
- [ ] Brief Rating Scale (e.g., BDI)
- [ ] Mental Status Exam
- [ ] Comprehensive Psycho-social-behavioral History
- [ ] Behavioral Observation

Please specify if administering standard battery or selected subtests only

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5. Clinical Questions	Specific Test(s) Requested	Hours
a. Intellectual		
b. Language		
c. Attention/Concentration		
d. Memory		
e. Executive Function		
f. Visual/Spatial		
g. Motor/Sensory		
h. Affective/Mood		

CPT Code(s) requested: ______________________ **Hours:** __________

______________________ __________

______________________ __________

Total Time Requested: __________

I hereby certify that I am the practitioner who will be performing the testing and the above statements are true and correct:

Name of Provider Provider TIN Signature of Provider/Date

Address City State Zip Code

Provider Telephone Number Provider Fax Number

Note: Incomplete forms may lead to delays in processing the request or lack of authorization.

PLEASE FAX FORMS TO:

MHNet Commercial and Medicare members: (724) 741-4556

CovCares of Virginia (Medicaid): (800) 586-7015

HCUSA (Medicaid): (866) 341-1327

CovCares of Kentucky (Medicaid): (844) 885-0699

CovCares of Michigan: (866) 603-5535