PRECERTIFICATION FOR NEUROPSYCHOLOGICAL/PSYCHOLOGICAL TESTING

In order to be authorized, psychological 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. Additionally, testing must not be available from any other source, and any previous psychological testing results are either unavailable or more than 18 months old. Testing requested primarily for legal, employment, vocational, or educational purposes is most often not a covered benefit.

Testing is encouraged only when clearly indicated and necessary for treatment. This report must be received and certified by HealthCare USA prior to testing. If testing is deemed clinically urgent and completion must be immediate, the request can be made by calling HealthCare USA at the Authorization number on the patient's ID card.

MEMBER INFORMATION			
Patient Name:		**DOB:**	**Age:**
Member ID#:			

CLINICAL INFORMATION				
Current Diagnoses under evaluation 5{a 袈、 Diagnoses				
R/O Diagnoses				
Current Acute Clinical Symptoms				
Patient referred to requesting Psychologist by: (Name, Degree, Specialty, Phone)				
Clinical Interview Data: (psycho/social/behavioral history, mental status exam, medications, impairments to functioning, etc):				
Purpose of testing (including referral questions, differential diagnostic issues to be addressed, how treatment plan will be affected by results of testing):				
Have Resources for psychological evaluation been explored through the patient's place of employment or school?	☐ Yes. Explain: ☐ No. Explain:			
Has the member had a psychiatric/diagnostic interview, observation in therapy, or an assessment at a mental health or substance abuse facility:	☐ Yes ☐ No			
Has the member ↑Ц Å тedications if so which ones:	☐ Yes. If yes, which ones: ☐ No			
Has the member had psychotherapy, if so dates of therapy	☐ Yes. If yes, dates: ☐ No			
Which of the following diagnostic/assessment techniques have been completed by ANY mental health professional/Neurologist:	☐ Diagnostic Interview ☐ Clinical Review ☐ Brief Rating Scale (e.g., BDI)	☐ Mental Status Exam ☐ Comprehensive psycho-social-behavioral history ☐ Behavioral Observation		

PRECERTIFICATION FOR PSYCHOLOGICAL TESTING

SERVICE BEING REQUESTED			
Clinical Questions		**Specific Test(s) Requested**	**Hours**
Organic Neuro	**Memory**		
	Language		
	Attention		
	Attention		
	Executive Function		
	Other		
Learning Disabilities (not usually a covered benefit)			
Affective/Behavioral			
Personality			
Other (e.g., evaluation for medical procedures (Gastric Bypass, Stimulator, Transplant))			

CPT Code(s) Requested:		**Hours:**	
		TOTAL TIME REQUEST	

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 (Please Print or Type) Provider TIN

Signature of Provider Date

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

PLEASE FAX FORMS TO:
HealthCare USA (Medicaid): (866) 341.1327