

Medicaid | Marketplace | Medicare

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□ KanCare (Medicaid)□ Ambetter (Health Insurance Marketplace)

☐ Wellcare by Allwell (Medicare Advantage)

SUBMIT TO

Utilization Management Department

Phone: 1-877-644-4623 Fax: 1-844-824-7705

NEUROPSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

Date							
PATIENT INFORMATION	PROVIDER	INFORMATION					
Name	Provider Nam	Provider Name					
Date of Birth	Group Name						
Member ID#	Provider Tax I	ID# NPI#					
Social Security #	Fax#	Phone#					
Health Plan #	Referral Source	Referral Source					
PROVISIONAL DSM-V DIAGNOSIS							
The provider must report all diagnoses being consider	dered for this patient.						
Primary	R/O	R/O R/O					
Secondary							
MEDICAL INFORMATION							
Testing is intended to answer these specific que	estions:						
These questions cannot be answered by a company of the compan							
☐ Yes ☐ No Details:							
4. Is cognitive impairment suspected or confirmed	d? Yes No Other:						
5. Is this a preoperative neuropsychological testin	g request related to surgical resection	n, transection, or thermal ablation for epilepsy?					
☐ Yes ☐ No Other:							
		ns? Yes No Other:					
7. If yes for number 6, did the evaluation show cog	gnitive deficits identified by screening	g test or obvious functional impairment?					
8. If yes for number 6, did the evaluation show syr	nptoms are not expected to respond	to acute or medical treatment or to resolve without					
treatment?							
9. Is patient on medication known to cause cognit	ive impairment and medication cann	not be discontinued?					
10. Is patient on medication and it's unknown whet	D. Is patient on medication and it's unknown whether drug effects are a cause of cognitive impairment?						
11. Is patient on medication and drug effects ruled	I. Is patient on medication and drug effects ruled out as cause of cognitive impairment? \Boxed Yes \Boxed No						
12. Does the patient have a substance-use disorde	r and sufficient length of abstinence b	before testing? ☐ Yes ☐ No					
13. Is it suspected or confirmed that the member h ☐ Traumatic brain injury confirmed by imaging or history of head injury with altered consciousness or post-traumatic amnesia	as experienced any of the following? Anoxic or hypoxic brain injury postoperative cognitive declin History of intracranial surgery	or					
14. If member has had a brain injury, did it occur m	ore than 30 days ago? 🗖 Yes 🗖 No	Other:					
15. If the member has had a brain injury, were symp	otoms present within the first 30 days	s and have persisted? 🗖 Yes 🗖 No					
Details:							
16 Has the patient had any previous neuropsychological	ngical testing? Type T No Detail	ile·					

17. If yes for number 14, has the pat	tient received a lifetime number of testi	ing episodes more than two	? ☐Yes ☐No	
18. If yes for number 14, was a neuro	ologic deficit confirmed by previous tes	sting? 🗆 Yes 🗖 No Deta	ails:	
19. Has the member experienced a	n unexpected change in symptoms witl	hin last four months?	es 🗖 No	
·	testing episode within last 12 months?			
	- '			
	response to new treatment?			
22. Is retesting planned to monitor	rehabilitation or functioning?	☐ No Details:		
PLEASE LIST	THE TESTS PLANNED TO	ANSWER THE CLIN	IICAL QUESTION(S):	
1.		2.		
3.		4.		
5.		6.		
	SERVICES I	REQUESTED		
CODE REQUESTED	UNITS REQUESTED	Т	IME FRAME REQUESTED	
Status exam:				
96116 (first hr)				
96121 (each additional hr)				
Test evaluation:				
96132 (first hr)				
96133 (each additional hour)				
Test administration and scoring	:			
96136 (first 30 min)				
96137 (each additional 30 min)				
96138 (first 30 min)				
96139 (additional 30 min)				
Automated testing and Result:				
96146				
Please feel free to attach additional	documentation to support your reques	st (e.g. updated treatment p	olan, progress notes, etc.).	
STANDARD REVIEW: Standard 14-day time frame will be applied.		EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.		
Clinician Signature	Date	Clinician Signature	Date SUBMIT TO Utilization Management Department Phone: 1-877-644-4623 Fax: 1-844-824-7705	