allwell. FROM sunflower health plan.

SUBMIT TO
Utilization Management Department
HMO 1-855-565-9519 • HMO D-SNP 1-833-402-6707
PPO 1-833-696-0634 • Fax: 1-844-824-7705

INPATIENT NEUROPSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

Date_____

PATIENT INFORMATION

Name _____

Date of Birth_____

Social Security #_____

Health Plan # _____

PROVIDER INFORMATION

Provider Name_____

Group Name _____

Provider Tax ID#_____NPI#_____

Fax#_____Phone#_____

FOR FOSTER CARE CHILDREN ONLY

Is this request court ordered? 0 Yes 0 No

Is this request required for placement? 0 Yes 0 No

Is this request mandated by the state's Child Welfare/Foster Care Agency? 0 Yes 0 No

MEDICAL INFORMATION

History of medical condition, trauma or substance use disorder that may have neuropsychological consequences to the patient:

Patient's cognitive symptoms/issues:

Patient's psychiatric symptoms/issues:

History of previous treatments for the above symptoms:

Will this testing all or in part be used for educational/vocational remediation? 0 Yes 0 No

If yes, please explain:

How will understanding the neuropsychological status of this patient affect the treatment plan?

What are the patient's diagnostic rule outs/referral questions?

Test Planned	Date Requested	Time Requested
1.		
2.		
3.		
4.		
5.		
6.		

I verify that the information provided within this report is an accurate representation of the patient's status and that I am privileged to administer this procedure.

Clinician Name	Clinician Signature	Date

SUBMIT TO
Utilization Management Department
HMO 1-855-565-9519 • HMO D-SNP 1-833-402-6707
PPO 1-833-696-0634 • Fax: 1-844-824-7705