Psychological / Neuropsychological Testing Request (Outpatient)

Fax completed form to: (866) 449-6843

Member: _____ DOB: _____ Age: _____

Member #: _____ Parent Name (if child member): _____

DSM-IV Diagnosis: _____ Referral Source: _____

Referral Question: _____

Relevant History: _____

_____

_____

Has the Member had a Psychiatric Evaluation? Y ☐ N ☐ If so, most recent date: _____

Past Assessment & Service Summary (e.g., testing, school eval / IEP / Early Intervention, ADHD dx/tx, behavior ratings):

_____

_____

_____

Tests Requested (may substitute with attached list):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Hours Requested (enter in box/boxes below):

Hours	CPT/Service: **Psychological Testing**	Hours	CPT/Service: **Neuropsychological Testing**

Provider Name & Degree: _____ License #: _____

TIN or SSN: _____ Agency or Facility: _____

Address: _____

Phone: _____ Fax: _____