



One Monarch Place · Suite 1500
Springfield, MA 01144-1500
413-787-4000 · 800-842-4464

NEUROPSYCHOLOGICAL TESTING PRIOR AUTHORIZATION

BEHAVIORAL HEALTH DEPARTMENT
PHONE: (413) 787-4000 EXT. 5028 FAX: (413) 233-2800

Please complete thoroughly. Send completed form to HNE Behavioral Health Department for review and decision.

MUST ENCLOSE RELEVANT CLINICAL DOCUMENTATION TO SUPPORT THIS REQUEST

SECTION A:

Date: _____ Patient Name: _____

Patient ID: _____ Patient Date of Birth: _____

SECTION B:

Referring Provider: _____ Provider ID: _____

Address: _____

Phone: _____ Office Manager/Contact Person: _____

Testing Provider: _____ Provider ID: _____

Address: _____

Phone: _____ Office Manager/Contact Person: _____

SECTION C:

Reason for Referral:

1. What is the clinical necessity for neuropsych testing? (i.e. clarify diagnosis, describe functional capabilities, etc.) _____

2. What has prevented the determination of accurate diagnosis or prevented treatment planning? _____

3. Re-testing

If requesting re-testing, describe change in clinical presentation and treatment planning. _____

Medical and Psychiatric History:

How does individual meet criteria for neuropsych testing? (i.e previous psychological testing done?; prior behavioral health evaluations?; relevant medical history?; relevant/significant substance abuse?) _____

FOR HNE USE ONLY	
<input type="checkbox"/> Testing approved	Authorization number: _____
Authorized units/days: _____	Effective from: _____ to _____
<input type="checkbox"/> Referring Provider Notified	<input type="checkbox"/> Person Contacted _____ Date/Time: _____ BH Specialist _____
Final notification to: <input type="checkbox"/> Testing Provider	<input type="checkbox"/> Patient/Family BH Associate _____