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TESTING PRIOR AUTHORIZATION REQUEST FORM

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

MUST CHECK ONE: NEUROPSYCHOLOGICAL PSYCHOLOGICAL

Please complete thoroughly. Fax to 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: _____ *HNE Provider ID #: _____

*Address: _____

*Contact person name and phone/ext.#: _____

*Testing Provider: _____ *HNE Provider ID #: _____

*Address: _____

*Phone: _____

*REQUIRED

SECTION C:

Reason for Referral: Check all that apply.

- Clarify diagnosis Re-testing Describe functional abilities and/or impairment

Specific clinical questions to address: _____

Psychiatric and Medical History:

Mental Health Diagnosis: _____

Substance Abuse Diagnosis: _____

Medical Diagnosis: _____

Relevant/Significant Medical Treatment: _____

Mental Health Treatment History: _____

Substance Abuse Treatment History: _____

Psychiatric Medication History: _____

Has a recent behavioral health evaluation been completed? Yes* No

*If yes, by whom? When? _____

Has there been prior psychological/neuropsychological testing? Yes* No

*If yes: When was testing completed? _____ By Whom? _____

Please attach reports.