



SUBMIT TO
Utilization Management Department
 12515-8 Research Blvd., Suite 400
 Austin, Texas 78759
 FAX 1.866.694.3649

INPATIENT NEUROPSYCHOLOGICAL TESTING AUTHORIZATION REQUEST FORM

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

Date _____

MEMBER INFORMATION

Name _____

Date of Birth _____

Member ID # _____

Health Plan _____

PROVIDER INFORMATION

Provider Name _____

Provider Tax ID# _____

Provider NPI/Sub Provider # _____

Phone _____ Fax _____

FOR FOSTER CARE CHILDREN ONLY

Is this request court ordered? Yes No

Is this request required for placement? Yes No

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

MEDICAL INFORMATION

History of medical condition, trauma or substance use 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? Yes 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.		

Have any questions?
 Call us at 1.866.912.6285

