magnolia health™

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

OUTPATIENT 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

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

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Date Received	Date Processed	Referral Source

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