

Psychological/Neuropsychological Testing Form

Please check the appropriate service you're requesting:

Psychological Testing

Neuropsychological Testing

Please check line of business for this form:

BlueCareSM

CoverKids

TennCare*Select*

Member Number: _____

Member Name: _____

Member Date of Birth: _____

Member Contact Number: _____

Date Request Sent: _____

Case Type: Psychological or Neuropsychological Testing

Provider Name: _____

Provider Phone: _____ Provider Fax: _____

UR Contact Name: _____ UR Contact Phone: _____

Place of Service: Office

Requesting Clinician: _____

Clinician Provider ID #: _____

Clinician NPI #: _____

Clinician Address:

Treating Clinician (list credentials): _____

Clinician Provider ID #: _____

Clinician NPI #: _____

Clinician Address:

Requested Facility: _____

Facility Provider ID #: _____

Facility NPI #: _____

Facility Address:

Psychiatric ICD-10 Diagnosis Codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Medical ICD-10 Diagnosis Codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Requested Start Date of Service: _____

(Note: If start date is prior to the request received date, it must be requested as a retrospective review and may be denied for non-compliance.)

Clinical Information Section

Date when member initiated request for this service: _____

Who initiated referral for psychological or neuropsychological testing?

Why is testing being requested at this time?

Describe how proposed testing will clarify diagnosis and impact future behavioral treatment:

Describe in detail the patient's current condition and symptoms:

Treatment History:

**Prior Testing and Date of Last Testing
(psychological, medical, psychiatric and neurological exams with results):**

Medications	Dose	Frequency	Dates	Outcome

Medication adherence? Barriers to adherence?

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Substance abuse concerns?

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If repeat testing is being requested, why is it needed at this time?

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Evaluation Services

(Note: One unit equals one hour.)

Integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning, report writing and feedback to patient/family member:

Service Activity	Time (units being requested)

Test Administration and Scoring

(Note: One unit equals 30 minutes.)

Specific psychological tests being requested (full name of test written out) with specified time for each one:

Test Name	Time (units being requested)

Test Administration and Scoring (continued)

Total Units Being Requested: _____

Signature of Ordering Clinician with Credentials (Required in order to process):

Date of Signature: _____

Fax Precertification Numbers:

BlueCare/TennCare *Select*: 1-800-292-5311

CoverKids: 1-800-851-2491

Provider Service Numbers:

BlueCare: 1-800-468-9736

TennCare *Select*: 1-800-276-1978

CoverKids: 1-800-924-7141



1 Cameron Hill Circle | Chattanooga, TN 37402 | bluecare.bcbst.com