dell children's
HEALTH PLAN

Request for Authorization: Neuropsychological Testing

Please submit this form electronically to Dell Children's Health Plan using our preferred method at **https://www.availity.com**.* This form can also be submitted via fax to **1-844-442-8011**.

General information

Member name:
Date of birth:
Dell Children's Health Plan member ID:
Provider completing testing:
Provider NPI or tax ID:
Provider phone:
Provider fax:
Provider address:
Provider email:
Referral source:
Referral source specialty:

* Availity, LLC is an independent company providing administrative support services on behalf of Dell Children's Health Plan.

Neuropsychological testing, also known as psychometric testing, is a comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders. This testing may be used to augment a comprehensive medical history and physical examination, as well as a neurological investigation of certain conditions.

Neuropsychological testing is considered medically necessary when there is evidence to suggest that the test results will have a timely and direct impact on the member's treatment plan for certain indications. Repeat testing to track the status of an illness, or the recovery progress, is subject to individual case consideration, but is generally not warranted.

Clinical information

Please include any relevant medical records to support the request for testing. Select all that apply.

☐ Traumatic brain injury, date: _____	☐ Encephalitis, date: _____	☐ Epilepsy and cognitive impairment suspected or documented, date: _____	☐ Multiple sclerosis and suspected or demonstrated cognitive impairment, date: _____
☐ Anoxic/hypoxic brain injury, date: _____	☐ CVA, date: _____	☐ Psychosis, date: _____	☐ Major affective disorder, date: _____
☐ History of intracranial surgery, date: _____	☐ Brain tumor in remission or with slow progression, date: _____	☐ Neurosurgery planned for epilepsy control, date: _____	☐ Head injury with loss of consciousness, date: _____
☐ Confirmed neurotoxin exposure, date: _____	☐ Dementia suspected, date: _____	☐ Other, date: _____	☐ Other, date: _____

Clinical assessment

Select all that apply.

☐ Clinical interview with patient, date: _____	☐ Psychiatric evaluation, date: _____	☐ Structured developmental/ psychosocial history, date: _____	☐ EEG, date: _____
☐ Neurologic exam, date: _____	☐ Neurobehavioral exam, date: _____	☐ Consultation with school or other important persons, date: _____	☐ Medical evaluation, date: _____
☐ Consultation with PCP, date: _____	☐ Brief rating scales or inventories, date: _____	☐ Neuroimaging (CT, MRI, PET), date: _____	☐ Interview with family member(s), date: _____

Date of clinical interview:
Enter other pertinent history or clinical information relevant to this request for neuropsychological testing.
Has the patient had previous psychological/neuropsychological testing? ☐ Yes ☐ No
If yes, date of testing:
What were the results and reasons for testing?
List medication(s) the patient is taking or mark the box if none. ☐ None
Have medication effects been ruled out as a cause of cognitive impairment? ☐ Yes ☐ No
Have alcohol and/or illicit substance effects been ruled out as a cause of cognitive impairment? ☐ Yes ☐ No
Enter the patient's substance abuse history to date or mark the box if none. ☐ None

What are the specific questions to be answered by neuropsychological testing that cannot be determined from the above services? How will the test results impact this patient's treatment?
Enter ICD-10 diagnoses under evaluation.

Neuropsychological tests and services being requested

CPT® code(s)	Units requested	Test names/service description
Total units requested:	Total time requested:	

Provider signature:	Date:

Authorization for neuropsychological testing is subject to verification of member eligibility and is not a guarantee of payment.

Note: We are unable to process illegible or incomplete requests.