group health Cooperative of eau claire

Neuro/Psychological Testing
Prior Authorization Request

An intake evaluation must be completed before a request for testing will be considered. Testing for learning disability, attention deficit disorders and disability evaluations is not covered. Rating scales, checklists, inventories and questionnaires are not reimbursed as testing.

Member Information		
Member Name (please print)	Date of Birth	Member ID
Please send a copy of the psychological intake.		
Diagnosis	ICD-10	Has the patient had previous testing? ☐ Yes ☐ No If yes, when? _____
What specific questions will be answered by the evaluation? 1. _____ 2. _____ 3. _____		
Describe how the evaluation will help to implement the treatment plan		

Specify the proposed measures and rationale for use		
Measure Name	CPT Code	Hours
Rationale		
Measure Name	CPT Code	Hours
Rationale		
Measure Name	CPT Code	Hours
Rationale		
Measure Name	CPT Code	Hours
Rationale		

Provider Information		
Provider Name	Facility Name	
Address	NPI	Tax ID
Contact Name	Phone	Fax
Please submit clinical documentation to support medical necessity for requested item.		

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Please fax completed form to: Group Health Cooperative of Eau Claire **Fax:** 715.552.7202 or 715.852.5755