



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? <input type="checkbox"/> Yes <input type="checkbox"/> 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		
Start Date		
Provider Information		
Practitioner Name	Practitioner Tax ID	Practitioner NPI
Facility Name	Facility Tax ID	Facility NPI
Facility Address		
UM Contact Name	UM Phone	UM 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