TESTING PRIOR AUTHORIZATION REQUEST FORM

- NEUROPSYCHOLOGICAL TESTING
- PSYCHOLOGICAL TESTING

HEALTH SERVICES DEPARTMENT
PHONE: 413.787.4000 EXT. 5027 FAX: 413.233.2800

Please complete thoroughly. Send completed form to Minuteman Health, Inc. (MHI) Health Services Department for review and decision.

MUST ENCLOSE RELEVANT CLINICAL DOCUMENTATION TO SUPPORT THIS REQUEST.

SECTION A:

Date: ____________ Patient Name: ____________

Patient ID: ____________ Patient Date of Birth: ____________

SECTION B:

Referring Provider: ____________ Provider ID: ____________

Address: ____________

Phone: ____________ Office Manager/Contact Person: ____________

Testing Provider: ____________ Provider ID: ____________

Address: ____________

Phone: ____________ Office Manager/Contact Person: ____________

SECTION C:

Reason for Referral: Check all that apply.

❑ Clarify diagnosis ❑ Describe functional abilities and/or impairment ❑ Re-testing

❑ Specific clinical questions to address: ____________

____

Medical and Psychiatric History:

❑ Diagnosis: Axis I: ____________

Axis II: ____________

Axis III: ____________

Axis IV: ____________

Axis V: ____________

❑ Relevant/Significant Medical History *(if applicable, please explain):* ____________

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❑ Mental Health Treatment History *(if applicable, please explain):* ____________

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❑ Substance Abuse Treatment History *(if applicable, please explain):* ____________

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❑ Psychiatric Medication History *(if applicable, please explain):* ____________

____

Has a current comprehensive clinical evaluation been completed? ❑ Yes* ❑ No

*If yes, by whom? ____________

Explain why a comprehensive clinical evaluation cannot answer your questions. Please be specific. ____________

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Has there been prior psychological/neuropsychological testing? ❑ Yes* ❑ No

*If yes, by whom? ____________

Have you seen the reports? ❑ Yes ❑ No

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