



NEUROPSYCHOLOGICAL TESTING AUTHORIZATION REQUEST

Patient's Name: _____ SSN#: _____ - _____ - _____ DOB: _____ / _____ / _____
Provider's Name: _____ Group Name: _____
Provider's Phone Number: (_____) _____ - _____ Fax: (_____) _____ - _____

History of medical condition, trauma, or substance use that may have neuropsychological consequences to the patient: _____

Patient's cognitive symptoms/issues: _____

Patient's psychiatric symptoms/issues: _____

History of previous treatment for the above symptoms? _____

Will this testing all or in part be used for educational/vocational remediation? Yes No
If yes, please explain: _____

How will understanding the neuropsychological status of this patient affect the treatment plan? _____

What are the patients diagnostic rule outs/referral question? _____

Test Planned:	Date Requested:	Time Requested:
1.		
2.		
3.		
4.		
5.		
6.		

I verify that the information provided within this report is an accurate representation of the patient's status and that I am privileged to administer this procedure.

Clinician Name

Clinician Signature

Date

SUBMIT TO:
Utilization Management Department
504 Lavaca, Suite 850
Austin, TX 78701
(800) 466-4089
FAX (866) 694-3649

Date Received: _____ Date Processed: _____ Referral Source: _____