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
12515-8 Research Blvd., Suite 400
Austin, TX 78759
(877) 647-4848
FAX (866) 694-3649

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