Humana
Behavioral Health

NeuroPsychological Testing Request Form

PRINT LEGIBLY *AND* COMPLETE ENTIRE FORM

Today's Date _____

Patient Name: _____ Patient DOB: _____

Insured Name: _____ Insured ID#: _____

Provider Name: _____ Provider Phone: _____

Provider Fax: _____

Insurance Co: _____

DSM-IV Diagnosis (Axis I - V)
Indicate any change in diagnostic presentation

Axis I: _____ _____ _____ R/O: _____

Axis II: _____ _____ _____ R/O: _____

Axis III: _____

Axis IV (Psychosocial Stressors): _____

Axis V - Current GAF: _____ Highest GAF in Past Year: _____

Presenting Problem (Include date problem began, duration): _____

Who is Requesting the Testing?: _____

Is a psychiatrist involved in the patient's care?: Yes No If No, Explain: _____

Describe how the treatment plan will be affected and/or improved by the results of testing: _____

Are there other reasons that may explain current symptoms/behaviors? (Physical or medical causes): _____

Names of tests to be performed and the number of hours requested for each:

NOTE: PRE-TESTING, PATIENT EVALUATION, AND REPORT WRITING IS INCLUDED AS PART OF LIFESYNCH RATES.

	TEST	HOURS		TEST	HOURS
1			6		
2			7		
3			8		
4			9		
5			10		

The provider is responsible for ensuring Humana Behavioral Health's receipt of this form. The provider will be notified of certification via mail or of denial via fax. Certifications are based on clinical criteria and are not a confirmation of benefit eligibility or guarantee of claim payment. Final determination of claim reimbursement is made at the time the claim is processed. All additional sessions must be pre-certified.

If form is incomplete or information is inadequate, additional information may be requested prior to a determination of certification.

Provider Signature: _____ Date: _____