Prior Authorization Request for Psychological and Neurological Testing Form

Tufts Health RITogether – Fax to 857.304.6404

Today's date: _____/_____/_____

Tufts Health Public Plans requires prior authorization for all psychological and/or neuropsychological testing requests. We will administratively deny services performed without prior authorization.

MEMBER INFORMATION

Please verify member eligibility before rendering services.

Name: _____

Member ID: _____ DOB:_____/_____/_____

SERVICING PROVIDER INFORMATION

Testing psychologist:_____ NPI#:_____

Agency: _____ Tax ID #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____

REQUESTING PROVIDER INFORMATION (if different than servicing provider)

Clinician requesting testing: _____NPI#:_____

Agency: _____ Tax ID #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____

Presenting problem and reason for prior authorization request:

_____

_____

_____

_____

Specific questions that testing could answer:

_____

_____

_____

Current symptoms/mental status: *Please include mood disturbance, psychosis, suicidal/homicidal ideation, past/present physical/sexual abuse and relational capacity.*

_____
_____
_____

Academic issues:

_____
_____

Was a case conference/CORE held at school? ☐ Yes ☐No If yes, when? **_____/_____/_____**
School name: _____ District: _____
Special education: ☐ Yes☐No Chapter 766: ☐ Yes ☐No IEP: ☐ Yes☐No

Previous psychological testing *Please summarize the results of any previous psychological testing.*

_____
_____
_____

Previous testing and results:

_____
_____
_____

Medical Issues *Please include any known pregnancy/birth complications, brain injury, head trauma, or lead poisoning.*

_____
_____
_____
_____

Date of last physical examination _____/_____/_____

Medications *Please include both psychiatric and medical medications.*

_____
_____
_____

History of substance abuse? ☐ Yes☐No

If yes, what substances? _____

Past/Present mental health treatment and dates *(e.g., psychiatric hospitalization, outpatient treatment)*

_____
_____

How will testing directly affect the treatment process?

_____

_____

How will results influence treatment decisions, facilitate treatment goals and/or provide information beyond what is currently available?

_____

_____

Diagnosis: ICD-10 code: _____

Psychological/neurological tests: *Please identify specific intervention, not the modality of counseling.*

Total Hours of authorized Testing

Psychological Testing	Neuropsychological Testing	Neuro-Behavioral Evaluation (prior authorization not required)
96130 = _____	96132 = _____	96116 = _____
96131 = _____	96133 = _____	96121 = _____
96136 = _____	96136 = _____	
96137 = _____	96137 = _____	
96138 = _____	96138 = _____	
96139 = _____	96139 = _____	
96146 = _____	96146 = _____	

Total Number of hours requested _____

If a licensed psychologist will conduct the test, please add the appropriate modifier to the CPT code on the claim. If a psychologist intern or PhD (under the supervision of a licensed psychologist) will conduct the test, add the appropriate modifier to the CPT code on the claim.

Dates when required testing will occur _____/_____/_____ *to* **_____/_____/_____**

Tests to be administered:

_____

_____

Best time and phone number to reach provider for prior authorization :

_____

Requesting provider signature_____

Date: _____/_____/_____

For Tufts Health Plan Use Only

Authorized dates to occur: _____/_____/_____ *to* _____/_____/_____

Procedures and units authorized:

_____

_____