Psychological and Neuropsychological Testing Request Form

Fax form to: (206) 652-7067
UM Department Phone: (800) 336-5231

PLEASE TYPE or WRITE LEGIBLY
or request will be returned as unable to process

MEMBER INFORMATION	
Member Name:	DOB:
Member ID:	If retroactively enrolled, provide enrollment date:

PROVIDER INFORMATION	
Provider Group/Clinic:	Contact Name:
Phone:	Fax:
Street Address:	City | State | Zip:
Provider ID/NPI:	
AUTHORIZATION REQUEST START DATE:	

DIAGNOSIS (Primary and any applicable co-occurring diagnoses- Code and Description)
1.
2.
3.
Psychological Stressors:

PRESENTING SYMPTOMS					
◯	Memory Loss	◯	Cognitive Decline	◯	Other (describe):
◯	Confusion	◯	None		

MEDICATION		
Please list medications, dosage and frequency below.	◯ Not applicable	
Name	Dosage	Frequency

PAST EVALUATIONS		
Date	Evaluation/Test	Outcome
/ /		
/ /		
/ /		

COMMUNITY HEALTH PLAN
of Washington™

REQUEST MEASURES AND RATIONALE FOR USE			
Measure	Rationale for Use	CPT Code	Hours Requested

ADDITIONAL QUESTIONS	
What is the purpose of testing and specific question(s) to be answered?	
Purpose:	
Question:	
Question:	
What strategies have been previously attempted to implement the treatment plan?	
1.	
2.	
3.	
How will the evaluation/testing assist in implementing the treatment plan?	
1.	
2.	
3.	
Have you consulted with the patient's PCP regarding the member's treatment plan or progress?	◯ Yes ◯ No

SIGNATURE	
I certify that I am the provider who will be delivering services listed above and that the information contained herein is true and correct to the best of my knowledge.	
Provider Name (print):	
Signature/Credential:	**Date:**