CenCal HEALTH®
Local. Quality. Healthcare.

Psychological/Neuropsychological Testing
Pre-Service Authorization Request Form

Please read the instructions carefully before submitting this form:

Psychological/Neuropsychological Testing must be pre-authorized using this form. Testing should not be administered until the requested authorization is approved. Please note that psychological or neuropsychological testing for purposes of educational, legal (including for child custody purposes) or disability applications is not a covered benefit.

Member Information

Member Name: _____   CenCal Member ID: _____

Member Date of Birth (DOB): _____

Requesting Provider (if different from service provider)

Name: _____

NPI: _____   Phone: _____

Relevant Information to Support Request

1. What is the primary diagnosis that will be the focus of this assessment?

_____   _____
Diag.#1   *Diag.#2*

_____   _____
Diag.#3   *Diag.#4*

2. Possible comorbid or alternative diagnoses:

_____   _____
Diag.#1   *Diag.#2*

_____   _____
Diag.#3   *Diag.#4*

3. What are the current symptoms and impairments of the member that warrants this assessment?

_____

4. What is the clinical question(s) that psychological/Neuropsychological testing will answer?
   Why is this assessment necessary at this time? *(Please be specific)*

_____

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5. Has a standard clinical evaluation and/or any other diagnostic evaluations been completed in the past 12 months? **If yes,** date of evaluation and name of provider. **If no,** please explain why a standard evaluation or additional diagnostic evaluations cannot answer the assessment questions.

6. How will the result of the psychological testing be used for the treatment plan? (be specific)

7. Other than the Member's PCP, who else might receive these testing results?
   (Please include the Organizational name, and/or Provider Group)

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8. Psychological/Neuropsychological tests likely to be used (Required to be completed for EACH)

Name of test	Test domain	How will this answer the purpose of testing

Provider completing request form

Print name of provider:

Signature of provider:

Date: NPI: