BlueCross BlueShield of Illinois

Psychological or Neuropsychological **Testing Request Form**

This is a request to review if the treatment meets the medical necessity definition under the member's health plan. It does not confirm the patient is eligible for benefits. Provider must call to verify benefits.

Blue Cross Community Health Plans: 877-860-2837 Blue Cross Community MMAI: 877-723-7702
After completing the form, please fax to 312-233-4099.

Request Submission Date:_____ Requested Testing Start Date:_____

Patient and Subscriber Information		
Patient Name	Date of Birth	
Subscriber Name	Subscriber ID #	Group #

Testing Provider Information ☐ Medical Practitioner ☐ BH Practitioner ☐ Inpatient ☐ BH Outpatient			
Name	Licensure	NPI:	
Address	City	ST	ZIP
Email Address	Phone #	Fax #	
Is the testing provider registered with the IMPACT System? ☐ Yes ☐ No *All providers not registered with the IMPACT system must call customer service for authorization.			
If requesting neuropsychological testing, are you a board certified neuro-psychologist? ☐ Yes ☐ No			

Utilization Review Contact Information		
Name	Phone #	Fax #

Referral Information	Who referred the patient for testing?	Name
Relationship to patient (i.e. PhD, PCP, Therapist, Medical Director, Parent, Psychiatrist, Teacher, School, etc.)		

Assessment History		
Have you met with the patient to complete a diagnostic evaluation? ☐ Yes ☐ No		
Has a diagnostic evaluation been completed by another provider? ☐ Yes ☐ No	If yes, the diagnostic evaluation was completed by?	
Name	Date	License Type
Has the patient had previous psychological testing? ☐ Yes ☐ No ☐ Not Sure		
Focus of Previous Testing:		

Current or Provisional Diagnosis		
Current DX — Please include all DSM 5 and/or medical diagnoses that apply.		
Code #:	DX Name:	Specifier:
Code #:	DX Name:	Specifier:
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What clinical/referral question(s) need to be answered by testing that cannot be answered by a diagnostic interview, medical/neurological consult or review of medical records?
What are the current symptoms and/or functional impairments related to the testing question(s)?

Requested Testing	Please include ALL tests that will be administered. If a test has multiple versions (i.e. parent, teacher, self-report), please indicate specifically which will be administered. If using selected subtests from a larger test please indicate which subtests will be administered.

CPT Testing Code Requested:	Total Hrs Requested per CPT Code:	Specify names of test attributed to this CPT Code:
1.		
2.		
3.		
4.		
5.		
Total Hours for testing requested:		

Other Comments	

My signature confirms that I, or the facility I represent, will provide the requested services.	
Signature:	Date:

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