

Psychological and Neuropsychological Testing Request Form



COMMUNITY HEALTH PLAN
of Washington™

Fax form to: (206) 652-7067
UM Department Phone: 800-440-1561

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

<input type="radio"/> Memory Loss	<input type="radio"/> Cognitive Decline	<input type="radio"/> Other (describe):
<input type="radio"/> Confusion	<input type="radio"/> None	

MEDICATION

Please list medications, dosage and frequency below. Not applicable

Name	Dosage	Frequency

PAST EVALUATIONS

Date	Evaluation/Test	Outcome
/ /		
/ /		
/ /		



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?	<input type="radio"/> Yes <input type="radio"/> 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: