



**CONFIDENTIAL – MEDICARE ADVANTAGE  
PRIOR AUTHORIZATION REQUEST FORM**

**PSYCHOLOGICAL &  
NEUROPSYCHOLOGICAL  
TESTING REQUEST**

**Required Information:** To ensure our patients receive quality and timely care, please complete this form in its entirety and submit with appropriate supporting clinical documentation.

<b>DATE OF REQUEST</b>

**Fax:** 1-888-972-2076  
**Phone:** 1-866-406-8027

**REVIEW PRIORITY LEVEL**

- Service requested can be reviewed within standard timelines. Standard review completed within 14 calendar days.
- The health or life of member may seriously be jeopardized if the service requested is not reviewed expeditiously. Expedited review completed within 72 hours.

**MEMBER INFORMATION**

<b>Member ID:</b>	<b>Last Name:</b>
<b>Date of Birth:</b>	<b>First Name:</b> <b>Middle Initial:</b>

**REQUESTING PROVIDER INFORMATION**

<b>Provider Network Status:</b>	<input type="checkbox"/> In Network Provider	<input type="checkbox"/> Out of Network Provider	
<b>Provider Service Location:</b>	<input type="checkbox"/> In Network Facility	<input type="checkbox"/> Out of Network Facility	
<b>NPI # / Tax ID:</b>	<b>Provider Last Name:</b>	<b>First Name:</b>	
	<b>Street Address:</b>		
<b>Facility/ Clinic/ Provider:</b>	<b>City:</b>	<b>State:</b>	<b>ZIP Code:</b>
	<b>Phone #:</b> (      )      -      -	<b>Fax #:</b> (      )      -      -	

**DIAGNOSIS**

*(If additional rows for diagnoses are required, include those additions as attachments to this page for supporting documentation.)*

- 1.
- 2.
- 3.

**Identify any Psychological Stressors:**

**PRESENTING SYMPTOMS**

- Cognitive Decline       Confusion       Memory Loss       None
- Other (please identify):

**MEDICATION(S)**

Medications Not Applicable

Name	Dosage	Frequency

**PAST EVALUATIONS**

Date	Evaluation / Test	Outcome

Authorization is not a guarantee of claim payment. The payment for these services is subject to using the authorized provider, your plan eligibility at the time of service, and the benefit limitations in your Evidence of Coverage.

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PSYCHOLOGICAL & NEUROPSYCHOLOGICAL TESTING REQUEST**

<b>PAST EVALUATIONS</b>			
<b>Measure</b>	<b>Rationale for Use</b>	<b>CPT Code</b>	<b>Hours Requested</b>

<b>ADDITIONAL QUESTIONS</b>
<b>1. What is the purpose of testing and specific question(s) to be answered?</b>
Purpose: Question: Question: Question:
<b>2. What strategies have been previously attempted to implement the treatment plan?</b>
1. 2. 3.
<b>3. How will the evaluation/testing assist in implementing the treatment plan?</b>
1. 2. 3.
<b>4. Have you consulted with the patient's PCP regarding the member's treatment plan or progress?</b>
<input type="checkbox"/> Yes, consultation occurred. (List date and attach any supporting clinical documentation.) Date  <input type="checkbox"/> No

Authorization is not a guarantee of claim payment. The payment for these services is subject to using the authorized provider, your plan eligibility at the time of service, and the benefit limitations in your Evidence of Coverage.

## Additional Instructions

### Prior Authorization Request for Psychological & Neuropsychological Testing Request

Please note that a traditional cover sheet may also be utilized as the first page of the fax as long as the completed prior authorization form is included as the second page in the transmission:

#### 1<sup>st</sup> Page

Your fax  
cover sheet

#### 2<sup>nd</sup> and 3<sup>rd</sup> Pages

Prior Authorization  
Request Form

#### 4<sup>th</sup> Page

Supporting Clinical  
Documents

Remember to provide the required information to ensure our members receive quality and timely care.

**This includes, but not limited to, completing this form in its entirety and submitting with appropriate supporting clinical documentation (i.e., H&P, imaging reports, surgical reports, and other pertinent admission records).**

After the fax is received by Bright Health, you will be contacted at the requesting phone number if there are any outstanding questions or concerns.

Confirmations for approved authorizations will be faxed to the requesting provider fax number.

#### Definition for Priority Level:

- **Standard request:** Bright Health must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date Bright Health receives the request.
- **Expedited request:** Member or any physician (regardless of whether the physician is affiliated with Bright Health), may request that Bright Health expedite the request when the member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

If you have any questions regarding this form and/or request, please contact provider services:

**1-844-201-4027**

8:00 a.m. – 6:00 p.m., local time

Monday – Friday, excluding federal holidays

Your Bright Health Team

# Fax - Confidential

**To:**

Bright Health Plan

**From:**

**Fax:**

1-888-972-2076

**Date:**

**Phone:**

**Re:**

Psychological-Neuropsychological Testing

Prior Authorization Request

## Additional Message