**Confidential – Individual & Family Plan**

# Psychological & Neuropsychological Testing Prior Authorization Request Form

**DATE OF REQUEST:** _____ **Fax:** 1-833-903-1067 | **Phone:** 1-844-990-0375

**Required Information:** To ensure our members receive quality and timely care, please complete this form in its entirety and submit with appropriate supporting clinical documentation (i.e. H&P, imaging reports, surgical reports, and other pertinent medical info.)

## Type of Service Request

☐ Service requested can be **reviewed within standard timelines.**

☐ The health or life of member **may seriously be jeopardized** if the service requested is not reviewed expeditiously.

## Member Information

| | |
|---|---|
| Member ID: (9-digit#, begins with 1) | |
| First Name: | Last Name: |
| Date of Birth: | Phone Number: |

## Requesting Provider Information

| | | | |
|---|---|---|---|
| NPI #: | Last Name: | First Name: | |
| Tax ID #: | Street Address: | | |
| Provider Type/Specialty: | City: | State: | Zip: |
| | Phone: | Fax: | |

## Servicing Provider Information

| | | | |
|---|---|---|---|
| NPI #: | Last Name: | First Name: | |
| Tax ID #: | Street Address: | | |
| Provider Type/Specialty: | City: | State: | Zip: |
| | Phone: | Fax: | |

## Servicing Facility Information

| | | | |
|---|---|---|---|
| NPI #: | Servicing Facility Name: | | |
| Tax ID #: | Street Address: | | |
| Facility Type: | City: | State: | Zip: |
| | Phone: | Fax: | |

## 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

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 Certificate of Coverage.

# PSYCHOLOGICAL & NEUROPSYCHOLOGICAL TESTING REQUEST

bright HEALTH

| Medications |
|---|
| ☐ Medications not applicable. |

| Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Past Evaluations | | |
|---|---|---|
| **Date** | **Evaluation / Test** | **Outcome** |
| | | |
| | | |
| | | |
| | | |
| | | |

| Past Evaluations | | | |
|---|---|---|---|
| **Measure** | **Rationale for Use** | **CPT Code** | **Hours Requested** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Additional Questions |
|---|
| **1. What is the purpose of testing and specific question(s) to be answered?** |
| Purpose:<br>Question:<br>Question: |
| **2. What strategies have been previously attempted to implement the treatment plan?** |
| 1.<br>2. |
| **3. How will the evaluation/testing assist in implementing the treatment plan?** |
| 1.<br>2. |
| **4. Have you consulted with the patient's PCP regarding the member's treatment plan or progress?** |
| ☐ Yes, consultation occurred (list date and attach any supporting clinical documentation) _____Date<br>☐ No |

## ADDITIONAL INSTRUCTIONS FOR SUBMITTING PRIOR AUTHORIZATION (PA)

This PA Request form is NOT intended for Bright Health's Medicare Advantage ("MA") plans. Please visit Availity.com or BrightHealthPlan.com for authorization request information related to MA products.

**STEP 1:** Complete your fax cover sheet (included on next page)

**STEP 2:** Complete your Individual & Family Plan Psych-Neuro Prior Authorization Request Form

**STEP 3:** Include all necessary supporting clinical documentation

After Bright Health receives your prior authorization request, you will be contacted at the requesting phone number if there are any questions.

### Prior Authorization Processing Time

| Utilization Review Timelines (calendar days) | | | | |
|---|---|---|---|---|
| **Category** | **Standard** | **Urgent** | **Concurrent** | **Retrospective** |
| **URAC Standard** | 15 calendar days | 72 hours | 24 hours | 30 calendar days |
| States following URAC: Alabama, Arizona, Ohio, Tennessee, Florida, Nebraska, Oklahoma | | | | |
| **Unique State Requirements** | | | | |
| **North Carolina** | 3 business days | | | 30 calendar days |
| **Colorado*** | 5 calendar days | Less of 2 business days/72 hours | 24 hours | 30 calendar days |
| **South Carolina** | 2 business days | | 1 business day | 2 business days |

**2020 IFP Statute Change*

Turn around times apply so long as complete documentation is submitted with the prior authorization request in order to make a determination.

**For faster processing: Please include all pertinent clinical documentation** to substantiate medical necessity of the requested service. Details and documentation may include:

- Reason the study is being requested (e.g., further evaluation, rule out a disorder)
- Symptoms and their duration, physical exam findings and progress notes, initial or follow up screening (if follow up, include outcome of previous screening and date)
- Conservative treatment (and its attempted duration) patient has already completed (e.g., physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications
- Preliminary procedures already completed (e.g., x-rays, CTs, lab work, ultrasound, referrals to specialist)
- Items/services are related to a confirmed rare disease diagnosis per NIH/National standards.

**Note:** Prior authorizations can be submitted electronically when requesting and servicing provider and/or facility is a contracted network provider or facility with Bright Health. Visit Bright Health's Provider Portal, Availity.com.

### Benefits of submitting PA forms electronically:

1. Providers **receive immediate confirmation** that a request was submitted successfully.
2. Providers **receive a reference number** for each prior-authorization submitted.
3. Providers **can view the current status** of a submitted prior-authorization at any time

### For any preventive screening tests/services

1. If **initial** age appropriate screening, note this on PA Form.
2. If **follow-up** age appropriate screening, note this on PA Form and include date of previous screenings and result of the screenings.
3. If member under age for recommended screening, submit clinical information stating initial or follow up screening and why it is needed. Also include results/date of previous screenings.

If you have any questions regarding this form and/or would like more information about Bright Health's Utilization Management program, please review our Provider Manual on the Provider Portal, Availity.com.

# Fax – Confidential

| | |
|---|---|
| **To: Bright Health Plan** | **From:** |
| **Fax: 1-833-903-1067** | **Date:** |
| **Phone:** | |
| **Re: Psychological & Neuropsychological Testing Prior Authorization Request** | |
| **Additional Message:** | |