

**Psychological & Neuropsychological Testing  
Prior Authorization Request Form****Date of Request:** \_\_\_\_\_ **Fax:** 1-833-903-1067 | **Phone:** 1-844-929-0162**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.

Review Priority Level			
<input type="checkbox"/> Service requested can be <b>reviewed within standard timelines</b> . Standard review completed within 14 calendar days.			
<input type="checkbox"/> The health or life of member <b>may seriously be jeopardized</b> if the service requested is not reviewed expeditiously. Expedited review completed within 72 hours.			
Member Information			
Member ID: (9-digit#, begins with 5):		Date of Birth:	Phone:
Last Name:	First Name:		MI:
Requesting Provider Information			
NPI #:	Last Name:		First Name:
Tax ID #:	Street Address:		
Facility/Clinic/Provider	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			
<input type="checkbox"/> Cognitive Decline <input type="checkbox"/> Confusion <input type="checkbox"/> Memory Loss <input type="checkbox"/> None			
<input type="checkbox"/> Other			
Medications			
<input type="checkbox"/> Medications not applicable.			
Name	Dosage	Frequency	

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.

Past Evaluations		
Date	Evaluation / Test	Outcome

Past Evaluations			
Measure	Rationale for Use	CPT Code	Hours Requested

Additional Questions
<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

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

<b>1st Page</b> Your fax cover sheet	<b>2nd &amp; 3rd Pages</b> Printed Authorization Request Form	<b>4th Page</b> Supporting Clinical Documents
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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.

**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](https://www.availity.com).

#### Benefits of submitting PA forms electronically:

1. Providers **receive immediate confirmation** that a request was submitted successfully.
2. The authorization submission process is streamlined by the type of authorization request. This **reduces back and forth between provider and payer**.
3. Providers **receive a reference number** for each prior-authorization submitted. Providers can **view the current status** of a submitted prior-authorization at any time.

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](https://www.availity.com).

# Fax – Confidential

<b>To: Bright Health Plan</b>	<b>From:</b>
<b>Fax: 1-833-903-1067</b>	<b>Date:</b>
<b>Phone:</b>	
<b>Re: Psychological &amp; Neuropsychological Testing Prior Authorization Request</b>	
<b>Additional Message:</b>	