

SUBMIT TO
Utilization Management Department
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Austin, TX 78741
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OUTPATIENT NEUROPSYCHOLOGICAL AND PSYCHOLOGICAL TESTING

Please print clearly- incomplete or illegible forms will delay processing.

PATIENT INFORMATION

Name: _____
Date of Birth: _____
Member ID#: _____
SocialSecurity #: _____

PROVIDER INFORMATION

Provider Name: _____
Group Name: _____
Phone: _____
Fax: _____
NPI Number: _____
Tax ID Number: _____

MEDICAL INFORMATION

History of medical condition, trauma or substance use disorder that may have neuropsychological consequences to the patient:

Patient's cognitive symptoms/issues:

Patient's psychiatric symptoms/ issues:

Will this testing all or in part be used for educational/vocational remediation? Yes No

If yes, please explain:

How will understanding the neuropsychological status of this patient affect the treatment plan?

What are the patient's diagnostic rule outs/ referral questions?

