Psychological & Neuropsychological Testing Pre-Authorization Request Form

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity® Provider Portal to submit pre-service prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross**. Please complete the clinical sections on this form and attach it to your request at www.Availity.com to ensure a timely review.

Providers outside of Minnesota or without electronic access can fax this form and complete clinical records to support the request, to **(651) 662-0854** or mail to: Utilization Management, P.O. Box 64265, St. Paul, MN 55164.

For review criteria related to Psychological and Neuropsychological testing, please see Blue Cross and Blue Shield of Minnesota Medical/Behavioral Policy X-45.

Patient Information

Member ID: (include alpha prefix) ____________________ Date of birth: ____________________

Member name: ____

Member address: ____

City/state/zip: ____

Phone: (_____) _______________

Servicing Provider Information

Contact person: ____

Phone: (_____) _______________ Fax: (_____) _______________

Clinic name: ________________________________ Clinic ID #: ________________

Individual provider ID/NPI number: ________________

Individual provider name: ____________________________ Degree/Lic: ________________

Provider address: ____

City/state/zip: ____

Case Background

Have you completed a psychiatric/psychological diagnostic assessment (DA) with this patient? **Please note: In most cases an initial diagnostic assessment must be completed before testing will be authorized.**

☐ Yes* ☐ No

***If yes, please submit a copy of the evaluation with this form.**

Date DA completed: ______________

Question		
Is the patient currently hospitalized?	☐ Yes*	☐ No
*If yes, is it medically necessary for testing to be done **prior to** discharge?	☐ Yes	☐ No
Is this patient in a pre-surgical status?	☐ Yes	☐ No
Are there currently any safety concerns regarding this patient?	☐ Yes	☐ No

If yes, what are those concerns? ____

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Diagnosis

ICD-10 diagnosis alpha-numeric code(s):

Rule out ICD-10 diagnosis alpha-numeric code(s):

Relevant medical conditions:

Diagnosis continued: Psychosocial and environmental problems:

Reason for Testing

What clinical question(s) will be answered by psychological/neuropsychological testing that cannot be answered through comprehensive diagnostic interview? Please include a description of clinical symptoms and functional impairment. Please also include information about any testing completed previously. Attach additional pages if needed.

Request Details

Request should include time for administration, scoring, interpretation and reporting. Brief rating scales, screening tools & questionnaires are considered incidental to the professional visit and should not be billed for separately. Please add additional codes if the requested code is not shown.

Test Name	Purpose of Test	Procedure Code and Units					
		Code	Units	Code	Units	Code	Units
		96116		96132		96138	
		96121		96133		96139	
		96130		96136		96146	
		96131		96137			
		Code	Units	Code	Units	Code	Units
		96116		96132		96138	
		96121		96133		96139	
		96130		96136		96146	
		96131		96137			
		Code	Units	Code	Units	Code	Units
		96116		96132		96138	
		96121		96133		96139	
		96130		96136		96146	
		96131		96137			

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Date range for authorization request: ____________ through ____________.

Total units requested: ________

Total hours requested: ________

I hereby attest that this information is true, accurate and complete to the best of my knowledge.

Signature: ____ **Date:** ___________________

If Technician procedure codes are requested, the following must be completed by the supervising provider.

Please note: CPT codes 96130, 96131, 96132, 96133, 96136 and 96137 cannot be used for technicians.

I attest to the following:

1) The services billed under the technician CPT code(s) will be delivered by an individual who has the appropriate training and experience to administer these tests;
2) The services will be delivered under my direct personal supervision;
3) The services will be provided in the office/facility where I render services;
4) My employment and supervision of the Technician complies with all applicable state laws and regulations including those governing independently licensed mental health professionals.

Signature: ____ **Date:** ___________________

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