Psychological Testing Request

Veteran's Name:	**DoD ID/Benefits # or Sponsor SSN:**
Evaluation Date:	**VA Auth Number:**

1. Veteran's Address:	2. Patient DOB: Age:
2. City:	State: Zip:
3. Telephone:	Telephone:
4. Veteran's Service Branch: ☐Army ☐Navy ☐USAF ☐USMC ☐USCG ☐Other	
5. Other Insurance: ☐ yes ☐ no If yes, please specify:	

6. Provider Name:	License Type:
7. Provider Telephone:	Fax:
8. Provider Address:	
City:	State: Zip:
9. Provider TIN:	Provider NPI:

10. **DSM-V Diagnosis** 1. _____ 2. _____ 3.	11. **Co-Occurring Medical Conditions (Relevant to Treatment)** 1. _____ 2. _____ 3.

12. Has the patient had a psychiatric hospitalization in the last 90 days: ☐ yes ☐ no

13. Relevant Clinical History:

14. Has the patient had previous psychological/neuropsychological testing? ☐ yes ☐ no
If yes, when and results:

15. Current Medications: ☐ yes ☐ no If yes, please mark below:

☐ Antianxiety Agents	☐ Antimania Agents	☐ Anticonvulsants
☐ Antidepressants	☐ Sedatives/Hypnotics	☐ Antiparkinsonian Agents
☐ Antipsychotic Agents	☐ Stimulants	☐ Other

16. Is patient currently abusing any substance? ☐ yes ☐ no If yes, please explain:

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17. What question(s) is psychological/neuropsychological assessment expected to answer?

Questions: 1.

2.

3.

18. What information is psychological/neuropsychological assessment expected to provide relevant to the treatment plan that cannot be determined by a diagnostic interview or a review of psychological/psychiatric records?

19. Please fill in the number of hours necessary for each required test

Proposed Test(s)	Hours Requested (per test)	Proposed Test(s)	Hours Requested (per test)
		Total hours of testing requested =	

20. Distribution of hours requested per CPT Service Code:

CPT Code	Description	Hours Requested (per CPT)
96101	Psychological Testing	
96102	Psychological Testing by Technician	
96103	Psychological Testing Administered by Computer	
96118	Neuropsychological Testing	
96119	Neuropsych Testing by Technician	
96120	Neuropsych Testing Administered by Computer	
90887	Testing Feedback/Explanation of Results to Family	

*These tests normally require ½ hour or less of professional time **For these batteries, please submit a list of the subtests and the amount of time requested for each subtest

Provider Signature: _____ Credentials: _____ Date: _____

Please fax the completed form to: 1-866-284-3736. Do not submit an RFS to TriWest.

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services. Privacy Act Statement - This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only." Violations of this may be punishable by fines, imprisonment, or both.

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