

# Request for Authorization: Neuropsychological Testing

New York | Medicaid

Please submit this form electronically using our preferred method via <https://Availity.com> from the care provider website at <https://anthembluecross.com/ny/provider>.

## General information

Member name:	
Member's date of birth:	Member ID #:
Professional administering testing:	
Provider name, if different than the professional administering the testing:	
Provider phone:	Provider fax:
Provider NPI:	Provider tax ID:
Provider address:	
Provider email:	
Billing facility/group name:	
Billing facility/group NPI:	Billing facility/group tax ID:
Billing facility/group address:	
Are services being rendered in person or via telehealth:	

Neuropsychological testing is a comprehensive evaluation of cognitive, motor, and behavioral functional abilities related to developmental, degenerative, and acquired brain disorders. Neuropsychological testing may be considered medically necessary when there is a cognitive or behavioral impairment related to a known or suspected medical or neurological condition. Testing must impact medical treatment planning. Testing may be medically necessary when a cognitive deficit requires quantification, monitoring of change, or differentiation of cause. Routine repeat testing is not generally warranted. However, repeat testing may be medically necessary with supporting medical documentation. Neuropsychological assessment is not considered medically necessary in the assessment of behavioral disorders, including ADHD.

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through the NY State of Health, The Official Health Plan Marketplace, visit [nystateofhealth.ny.gov](http://nystateofhealth.ny.gov) or call 855-355-5777.

Medicaid coverage provided by Anthem Blue Cross and Blue Shield HP, trade name of Anthem HP, LLC. Independent licensee of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

<b>Clinical information (include any relevant medical records to support the request for testing).</b>			
<input type="checkbox"/> Traumatic brain injury date:	<input type="checkbox"/> Encephalitis date:	<input type="checkbox"/> Epilepsy and cognitive impairment suspected or documented date:	<input type="checkbox"/> Multiple sclerosis and suspected/demonstrated cognitive impairment date:
<input type="checkbox"/> Anoxic/hypoxic brain injury date:	<input type="checkbox"/> CVA date:	<input type="checkbox"/> Genetic disorder date:	<input type="checkbox"/> Hydrocephalus date:
<input type="checkbox"/> History of intracranial surgery date:	<input type="checkbox"/> Cerebral mass date:	<input type="checkbox"/> Neurosurgery planned for epilepsy control date:	<input type="checkbox"/> Mild cognitive impairment:
<input type="checkbox"/> Confirmed neurotoxin exposure, including cancer treatments date:	<input type="checkbox"/> Dementia suspected date:	<input type="checkbox"/> Parkinson's and other motor diseases date:	<input type="checkbox"/> Other date:

<b>Clinical assessment</b>			
<input type="checkbox"/> Clinical interview date:	<input type="checkbox"/> Psychiatric evaluation date:	<input type="checkbox"/> Structured developmental/ psychosocial history date:	<input type="checkbox"/> EEG date:
<input type="checkbox"/> Neurologic exam, date:	<input type="checkbox"/> Neurobehavioral exam date:	<input type="checkbox"/> Consultation with school or other important people date:	<input type="checkbox"/> Medical evaluation date:

Clinical assessment			
<input type="checkbox"/> Consultation with PCP date:	<input type="checkbox"/> Brief rating scales or inventories date:	<input type="checkbox"/> Neuroimaging (CT, MRI, PET) date:	<input type="checkbox"/> Other date:

Other pertinent information
Enter other pertinent history or clinical information relevant to this request for neuropsychological testing.
Has the patient had previous psychological or neuropsychological testing? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter the date of testing: ____/____/____.
What were the results and reasons for testing?
List the medication(s) the patient is taking or mark the box if none. <input type="checkbox"/> None
Enter the patient's substance use history to date or mark the box if none. <input type="checkbox"/> None Have alcohol and/or illicit substance effects been ruled out as a cause of cognitive impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Rationale for testing: What are the specific questions to be answered by neuropsychological testing?  How will the test results impact this patient's treatment?

**ICD-10-CM diagnoses under evaluation**

Code(s)	Current or provisional	
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional

Neuropsychological tests requested: Please list the tests you are requesting and the expected administration time. For tests with multiple versions, specify which one. If you are administering selected subtests, please indicate which ones. Attach a separate sheet if necessary.

CPT® code(s)	Unit(s) requested	Evaluation services to be completed, and test names to be administered
<input type="checkbox"/> <b>96132</b> <b>(Base Code)</b>		
<input type="checkbox"/> <b>96133</b> <b>(Add-on code to 96132)</b>		
<input type="checkbox"/> <b>96136</b> <b>(Base Code)</b>		
<input type="checkbox"/> <b>96137</b> <b>(Add-on code to 96136)</b>		
<input type="checkbox"/> <b>96138</b>		
<input type="checkbox"/> <b>96139</b> <b>(Add-on code to 96138)</b>		
<b>Total units requested:</b>		<b>Total time requested:</b>

**Provider signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_