Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Request for Psychological & Neuropsychological Testing

Patient Name _____ Enrollee ID _____ Date of Birth_____

1. Have you evaluated the member clinically with at least one face-to-face session? Yes __ No __
2. Will you continue to see the patient after testing is completed? Yes __ No __
3. What is the provisional or rule out diagnosis(es)? _____
4. Are job/school related measures of function available? Yes __ No __ If so, what do they indicate _____

_____

_____

5. Is there collateral information documenting job or school functioning problems? Yes __ No __ If so, what do they indicate?

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6. Briefly describe the patient and the clinical issues which need clarification with psychological testing: _____

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7. How will the information gained from psychological testing impact the patient's treatment plan:

_____

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8. Please list the following tests and associated units for each test. (Please attach additional pages if needed.)

Tests Completed to Date	Covered Codes	Proposed Tests	Testing Code	# of Units
	96136 initial 30 min. 96137 additional 30min. 96138 initial 30min. 96139 additional 30min. 96130 initial hour 96131 additional hour 96132 initial hour 96133 additional hour *Approved for: PhD, PsyD, LPA & Psychiatrist*			
		Total Units Requested:	=	

Person conducting testing: _____ Address: _____ Phone #: _____

Submitted by: _____ Direct Phone #: _____ Date: _____

Mail form to: CBHA, Box 571137, Winston-Salem, NC 27157-1137 or FAX form to: (336) 499-4006

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