



CARELON BEHAVIORAL HEALTH PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL ASSESSMENT SUPPLEMENTAL FORM

Provide specific information in context of each health plan's unique medical necessity criteria which are available on each plan's website or by request.

IDENTIFYING INFORMATION	
Dates of Service Requested: (Start)____/____/____ (End)____/____/____	
First Name:	Last Name: MI:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Other:
Policy Number:	
Health Plan:	
Date Form Submitted:	Preferred Language (if other than English):
Servicing Clinician:	Facility:
Phone Number:	TIN/NPI#:
Name and Role of Referring Individual:	<input type="checkbox"/> Self Referred
Contact Person:	Best Time to Contact:
Phone Number:	Fax:
Email:	
Site Address:	
Requesting Clinician/Facility (only if different than service provider):	
Phone Number:	TIN/NPI#:
Contact Person:	Best Time to Contact:
Phone Number:	Fax:
Email:	
RELEVANT DIAGNOSTIC DATA	
Primary possible diagnosis which is the focus of this assessment:	
Possible comorbid or alternative diagnoses:	<input type="checkbox"/> None
List all other relevant medical/neurological or psychiatric conditions suspected or confirmed:	<input type="checkbox"/> None
Relevant results of imaging or other diagnostic procedures (provide dates for each):	<input type="checkbox"/> None
ASSESSMENT PLAN AND HISTORY	
Psychological and Neuropsychological Test Evaluation Services	Psychological and Neuropsychological Test Administration and Scoring
<i>Please enter number of units requested</i>	<i>Please enter number of units requested</i>
Psychological Testing Evaluation Services, 1 st hour 96130=___	Test Admin by Professional, first 30 minutes 96136=___
Additional hour (List Separately) 96131=___	Additional 30 minutes (List separately) 96137=___
Neuropsychological Testing Evaluation Service, 1 st hour 96132=___	Test Admin by Technician, first 30 minutes 96138=___
Additional hour (List Separately) 96133=___	Additional 30 minutes (List separately) 96139=___
Automated Testing and Result 96146=___	Neurobehavioral status exam, 1 st hour 96116=___
	Additional hour (List separately) 96121=___

List Likely Tests:	
What suspected or confirmed factors suggested that assessment may require more time relative to test standardization samples:	
<input type="checkbox"/> Depressed mood <input type="checkbox"/> Low frustration tolerance <input type="checkbox"/> Vegetative symptom <input type="checkbox"/> Grapho-motor deficits <input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Physical symptoms or conditions (such as): <input type="checkbox"/> Suspected processing speed deficits <input type="checkbox"/> Performance Anxiety <input type="checkbox"/> Receptive communication difficulties
Why is this assessment necessary at this time:	
<input type="checkbox"/> Contribute necessary clinical information for differential diagnosis including but not limited to assessment of the severity and pervasiveness of symptoms; and ruling out potential comorbidities. <input type="checkbox"/> Results will help formulate or reformulate a comprehensive and optimally effective treatment plan. <input type="checkbox"/> Assessment of treatment response or progress when the therapeutic response is significantly different than expected. <input type="checkbox"/> Evaluation of a member's functional capability to participate in health care treatment <input type="checkbox"/> Determine the clinical and functional significance of brain abnormality. <input type="checkbox"/> Dangerousness Assessment <input type="checkbox"/> Assess mood and personality characteristics impact experience or perception of pain. <input type="checkbox"/> Other (describe):	
Has a standard clinical evaluation been completed in the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N	
If yes, when and by whom:	
If no, explain why a standard clinical evaluation cannot answer the assessment questions:	
Date of last known assessment of this type: <input type="checkbox"/> No prior testing	
If testing in past year, why are these services necessary now:	
<input type="checkbox"/> Unexpected change in symptoms <input type="checkbox"/> Evaluate response to treatment <input type="checkbox"/> Assess function	<input type="checkbox"/> Previous assessment is likely invalid <input type="checkbox"/> Other (please specify):
Are units requested for the primary purpose of differentiating between medical, psychiatric conditions, learning disorders and/or guiding health care services? <input type="checkbox"/> Y <input type="checkbox"/> N	
Are the units requested for the primary purpose of determining special needs educational programs? <input type="checkbox"/> Y <input type="checkbox"/> N	
Are the units requested to answer questions of law under a court order? <input type="checkbox"/> Y <input type="checkbox"/> N	
Currently known symptoms and functional impairments of the patient that warrant this assessment:	
RELEVANT MENTAL HEALTH/SUD HISTORY	
Relevant Mental Health History: <input type="checkbox"/> None	
Is substance use disorder suspected? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many days of sobriety:
Are medication effects a likely and primary cause of the impairment being assessed? <input type="checkbox"/> Y <input type="checkbox"/> N	
If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly? <input type="checkbox"/> Y <input type="checkbox"/> N	
If no, explain why testing is necessary:	

If the primary diagnosis is ADHD, indicate why the evaluation is not routine:

- Previous treatment(s) have failed and testing is required to reformulate the treatment plan
- A conclusive diagnosis was not determined by a standard examination
- And/or specific deficits related to or co-existing with ADHD need to be further evaluated
- Other (please specify):

Signature of requesting clinician:
