# Psychological and Neuropsychological Testing Request Form

COMMUNITY HEALTH PLAN of Washington™
APPLE HEALTH (MEDICAID) MEDICARE ADVANTAGE

COMMUNITY HEALTH NETWORK of Washington™
CASCADE SELECT

**Fax form to: 206-652-7067**
**Medicaid 1-800-440-1561**
**Medicare 1-800-942-0247**
**CHNW Cascade Select 1-866-907-1906**

**PLEASE TYPE or WRITE LEGIBLY** or request will be returned as unable to process

| MEMBER INFORMATION | |
|---|---|
| Member Name: | DOB: |
| Member ID: | If retroactively enrolled, provide enrollment date: |

| PROVIDER INFORMATION | |
|---|---|
| Provider Group/Clinic: | Contact Name: |
| Phone: | Fax: |
| Street Address: | City \| State \| Zip: |
| Provider ID/NPI: | |
| **AUTHORIZATION REQUEST START DATE:** | |

| DIAGNOSIS<br>(Primary and any applicable co-occurring diagnoses- Code and Description) |
|---|
| 1. |
| 2. |
| 3. |
| Psychological Stressors: |

| PRESENTING SYMPTOMS | | | | | |
|---|---|---|---|---|---|
| ○ | Memory Loss | ○ | Cognitive Decline | ○ | Other (describe): |
| ○ | Confusion | ○ | None | | |

| MEDICATION | | |
|---|---|---|
| Please list medications, dosage and frequency below. ○ Not applicable | | |
| Name | Dosage | Frequency |
| | | |
| | | |
| | | |

| PAST EVALUATIONS | | |
|---|---|---|
| Date | Evaluation/Test | Outcome |
| / / | | |
| / / | | |
| / / | | |

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| REQUEST MEASURES AND RATIONALE FOR USE | | | |
|---|---|---|---|
| Measure | Rationale for Use | CPT Code | Hours Requested |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| ADDITIONAL QUESTIONS | |
|---|---|
| What is the purpose of testing and specific question(s) to be answered? | |
| Purpose: | |
| Question: | |
| Question: | |
| What strategies have been previously attempted to implement the treatment plan? | |
| 1. | |
| 2. | |
| 3. | |
| How will the evaluation/testing assist in implementing the treatment plan? | |
| 1. | |
| 2. | |
| 3. | |
| Have you consulted with the patient's PCP regarding the member's treatment plan or progress? | ◯ Yes ◯ No |

| SIGNATURE | |
|---|---|
| I certify that I am the provider who will be delivering services listed above and that the information contained herein is true and correct to the best of my knowledge. | |
| **Provider Name (print):** | |
| **Signature/Credential:** | **Date:** |