CLEAR FORM

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: ☐ Male ☐ Female Other: _____	
Policy Number:		
Health Plan:	Health Plan Fax #:	
Date Form Submitted:		
Servicing Clinician:	**Facility:**	
Address:		
Phone Number:	NPI:	TIN:
Name and Role of Referring Individual:	☐ Self Referred	
Contact Person:	Best Time to Contact:	
Phone Number:	Fax:	
Email:		
Requesting Clinician/Facility *(only if different than service provider)*:		
Address:		
Phone Number:	NPI:	TIN:
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: ☐ None

List all other relevant medical/neurological or psychiatric conditions suspected or confirmed: ☐ None

Relevant results of imaging or other diagnostic procedures (provide dates for each): ☐ None

CPT CODES REQUESTED

Psychological Testing Evaluation (per 60 minutes)	Neuropsychological Testing Evaluation (per 60 minutes)	Neurobehavioral Status Evaluation
96130 = _____	96132 = _____	96116 = _____
96131 = _____	96133 = _____	96121 = _____
Test Administration (per 30 minutes)	Test Administration (per 30 minutes)	
96136 = _____	96136 = _____	
96137 = _____	96137 = _____	
96138 = _____	96138 = _____	
96139 = _____	96139 = _____	

List Likely Tests:

What suspected or confirmed factors suggest that assessment may require more time relative to test standardization samples?

- ☐ Depressed mood
- ☐ Low frustration tolerance
- ☐ Vegetative symptom
- ☐ Grapho-motor deficits
- ☐ Suspected processing speed deficits
- ☐ Physical symptoms or conditions such as: _____
- ☐ Performance anxiety
- ☐ Receptive communication difficulties
- ☐ Other: _____

(continued on next page)

Why is this assessment necessary at this time?

- ☐ 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.
- ☐ Results will help formulate or reformulate a comprehensive and optimally effective treatment plan.
- ☐ Assessment of treatment response or progress when the therapeutic response is significantly different than expected.
- ☐ Evaluation of a member's functional capability to participate in health care treatment.
- ☐ Determine the clinical and functional significance of brain abnormality.
- ☐ Dangerousness Assessment.
- ☐ Assess mood and personality characteristics impact experience or perception of pain.
- ☐ Other (describe): _____

Has a standard clinical evaluation been completed in the past 12 months? ☐ Y ☐ N

If yes, when and by whom?

Explain why a standard clinical evaluation was not or would not be able to answer the assessment questions.

Date of last known assessment of this type: ☐ No prior testing

If testing in past year, why are these services necessary now?

- ☐ Unexpected change in symptoms
- ☐ Evaluate response to treatment
- ☐ Assess function
- ☐ Previous assessment is likely invalid
- ☐ Other (specify): _____

Are units requested for the primary purpose of differentiating between medical, psychiatric conditions, and/or learning disorders and/or guiding *health care services*? ☐ Y ☐ N

Are the units requested for the primary purpose of determining special needs educational programs? ☐ Y ☐ N

Are the units requested to answer questions of law under a court order? ☐ Y ☐ N

What are the patient's currently known symptoms and functional impairments that warrant this assessment? If neuropsych assessment is requested, clearly describe specific cognitive impairments and suspected brain insult.

RELEVANT MENTAL HEALTH/SA HISTORY

Relevant Mental Health History: ☐ None

Is substance use/dependence suspected? ☐ Y ☒ N	If yes, how many day of sobriety?

Are medication effects a likely and primary cause of the impairment being assessed ☐ Y ☐ N

If yes, is this assessment necessary to evaluate the impact of medication on cognitive impairment and inform clinical planning accordingly ☐ Y ☐ 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: _____

Signature of requesting clinician: _____

Providers may attach any additional data relevant to medical necessity criteria.