CDPHP Behavioral Health Services
6 Wellness Way
Latham, NY 12110
Phone: (518) 641-3600
Fax: (518) 641-3601

Psychological and Neuropsychological Testing Request Form

Provider **must** receive authorization for all testing beyond the six allotted hours.

Member's Name:_____ **Member's DOB:** ____ /____ /____

Subscriber's Insurance #: _____

Testing Dates of Service Requested: Start: ____ /____ /____ End: ____ /____ /____

Tester:_____ **NPI #:** _____

Degree: _____ **Type of License:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____

Has a diagnostic interview (90791/90792) taken place? ☐ Yes ☐ No

Date diagnostic interview completed: ____ /____ /____

Provider Who Referred Member to Psychologist for Testing:

Name: _____ **Degree:** _____

Specialty: _____ **Phone:** (_____) _____ - _____

Case Background:
(Include current level of care, relevant symptoms, treatment history, previous attempts to answer diagnostic questions including dates and types of previous psychological/neuropsychological testing, psychotropic medications, risk factors, co-occurring substance disorders and medical conditions, MRI, EEG, CAT scan, X-rays, etc.)

CDPHP Psychological and Neuropsychological Testing Request Form

Member's Name:_____ **Member's DOB:** ____ /____ /_____

Purpose of Testing: *(Specify referral questions, outstanding issues related to differential diagnosis, contributions to the clinical treatment plan.)*

DSM 5 Diagnosis(es):

Rule Out Diagnosis(es) to be Evaluated:

List All Tests Required ***(please spell out names of test)*****:**

Total Units of Testing (including the first six hours which do not require authorization):

Psychological Testing:	96130 = _____	96131 = _____
	96136 = _____	96137 = _____
Neuropsychological Testing: Evaluation:	96116 = _____	96121 = _____
	96132 = _____	96133 = _____
	96136 = _____	96137 = _____

Post-service Request? ☐ Yes ☐ No

(If yes, state service date range) Start: ____ /____ /____ End: ____ /____ /____

Court-ordered? ☐ Yes ☐ No

Exchange of Information Form

This is not a request for medical records.

CDPHP requires contracted behavioral health providers to coordinate treatment with primary care practitioners (PCPs) and other behavioral health providers involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member.

Patient Name: _____ **DOB:** _____

Date mailed or faxed to other clinician/facility: _____

Treating Behavioral Health Clinician/Facility Information:

Name: _____ Phone: _____

Address: _____ Fax: _____

PCP or Other Behavioral Health Clinician/Facility/Information:

Name: _____ Phone: _____

Address: _____ Fax: _____

Please be advised that I saw a patient from your practice for a medical/mental health/substance evaluation:

Diagnostic description: _____

_____

Medications: _____

_____

Other treating health care professionals involved in this patient's treatment: _____

_____

Treatment recommendations:

☐ Individual Therapy ☐ Medication Management ☐ Family Therapy ☐ Medical Treatment

☐ Group Therapy ☐ Substance Abuse Treatment ☐ Couples Therapy

☐ Other: _____

If you have any questions, please feel free to contact me.

Sincerely,

_____ _____ _____

Print Name Credentials Phone Number

To the party receiving this information: If information is disclosed from alcohol or substance abuse records protected by Federal confidentiality rules (42 CFR Part 2), those rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by these rules.

Member Consent: I hereby authorize the behavioral health clinician/facility listed above to release the information contained on this form to the practitioner/provider listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent in writing at any time except to the extent that the practitioner or entity which is to make the disclosure has already acted in reliance on it. I understand that my treatment is not conditional in any way on my consenting to this disclosure.

Place a completed copy of this form in the patient's medical record and provide signed copy to the patient.

I do not want to have information shared with:

☐ My PCP/medical practitioner. ☐ My other behavioral health practitioner(s)/provider(s)

☐ I am not currently receiving services from a PCP/other medical practitioner.

☐ I am not currently receiving services from any other behavioral health practitioner/provider.

_____ _____

Patient Signature *(If other than patient, state relationship to patient)* **Date**

_____ _____

Clinician/Facility Representative Signature **Date**