BlueCross BlueShield of Texas

Psychological or Neuropsychological
TESTING REQUEST FORM

Provider must call BCBSTX at **800-528-7264** to verify benefits. To expedite the processing of your request, please complete all sections of the form. Please fax to BCBSTX at **877-361-7646.**

Request Submission Date ____________________ Requested Testing Start Date ____________________

Patient and Subscriber Information

Patient name ____________________ **Patient date of birth** ____________________

Subscriber name ____________________ **Subscriber ID** __________ **Group** __________

Rendering Provider Information

Type of licensure ____________________
(Example: Psychologist, Psychiatrist, MD, PhD, PsyD)

Billing name ____________________ **NPI** __________ **Group name** ____________________

Rendering name ____________________ **NPI** ____________________

Address ____________________ **City** __________ **State** ______ **Zip** ______

Email address ____________________ **Phone** __________ **Fax** __________

Are you a clinical neuropsychologist? ☐ Yes ☐ No

Office contact name ____________________ **Phone** __________

Referral Information

Who referred the patient for testing? Name ____________________

Relationship to patient (i.e. self, PCP, Therapist, Parent, Psychiatrist, Teacher, School, etc.) ____________________

Assessment History

Have you met with the patient to complete a diagnostic evaluation? ☐ Yes ☐ No **If yes, date** __________

Has a diagnostic evaluation been completed by another provider? ☐ Yes ☐ No

If yes, who completed the diagnostic evaluation? Name __________ Date __________ License Type __________

Has the patient had previous psychological/neuropsychological testing? ☐ Yes, when? __________ ☐ No ☐ Not sure

Focus of previous testing ____________________

Current DX — Please include all DSM 5, ICD 10 and/or medical diagnoses that apply.

Code __________ DX Name ____________________ Specifier ____________________
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What clinical/referral question(s) need to be answered by testing that cannot be answered by a diagnostic interview, medical/neurological consult or review of medical records?

What are the current symptoms and/or functional impairments related to the testing question(s)?

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Patient Name ____

Requested Testing

Please include ALL tests that will be administered. If a test has multiple versions (i.e. parent, teacher, self-report), please indicate specifically which will be administered. If using selected subtests from a larger test, please indicate which subtests will be administered.

Will a technician be providing any services for this evaluation? ☐ Yes ☐ No

Technician name ____ **Credentials** ____

Please list the applicable technician CPT codes below.

CPT Testing Code Requested	Total Units Requested per CPT Code	Specify names of tests or type of service attributed to this CPT code
1		
2		
3		
4		
5		
6		
7		
8		

Total Units Requested _____________________________

Other Comments

My signature confirms that I am providing the requested services:

Signature ____ Date ___________________

Print name ____